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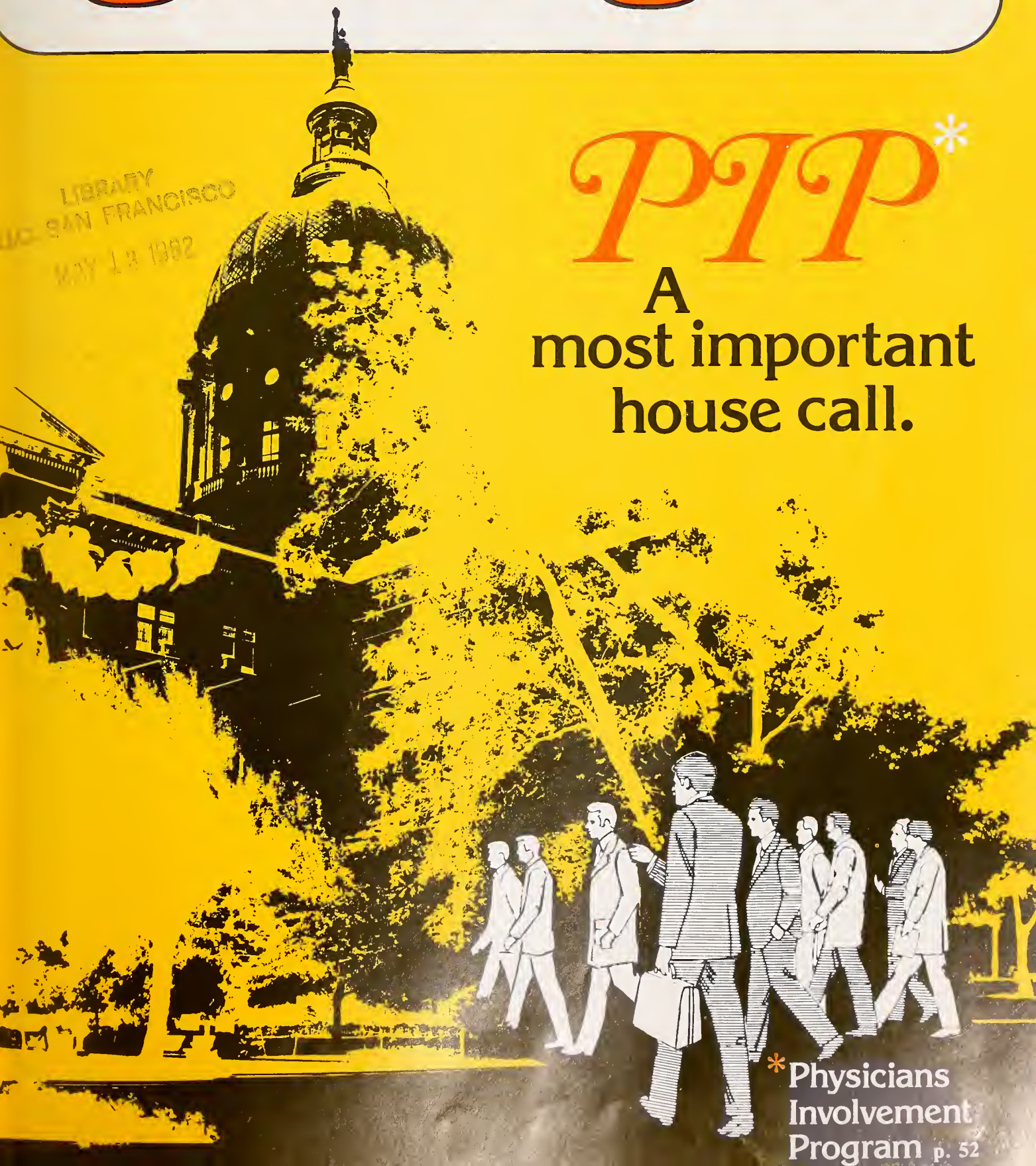
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JOURNAL
of the medical association of
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PIP*

A most important house call.



*Physicians Involvement Program p. 52

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THE COVER

The Physicians Involvement Program (PIP) is one of the most imprtant elements of the MAG legislative activities. Read about the experience of doctors who participated in PIP last year, (p. 52). Join your colleagues at the '82 General Assembly and make a difference.

Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

The 1981 MAG Scientific Assembly

Specialty societies come together.
MAG handles the details.
You get the rewards.

This is the way the MAG billed its seventh annual Scientific Assembly, held Nov. 20-22, 1981, at the Omni International Hotel in Atlanta. Once again, the Assembly was a success, as some 800 physicians and allied health professionals attended specialty society meetings.

Fifteen specialties, from allergy to surgery, were represented by educational programs. In each case, the society chose its program chairman, who in turn selected topics and speakers to meet the needs of his/her colleagues. A glance at the program indicates the variety of medical education topics made available under the MAG's "umbrella": asthma; interstitial lung disease; common emergency cases; esophageal reflux; angioplasty; pituitary disease; glaucoma; internal fixation of fractures; surgical repair of the eyelid; the pathology of OB/GYN; reconstruction of the abdominal wall; hypnosis in medicine; and surgical treatment of breast cancer.

A number of societies use the Scientific Assembly as a forum for business meetings, luncheons, and receptions. The Georgia Society of Internal Medicine, for instance, held its annual luncheon on Friday the 20th with Dr. T. Reginald Harris, Secretary-Treasurer of the ASIM, speaking on, "The Impact of the Reagan Administration on Office-Based Physicians." His speech is included in this issue of the *Journal*.

For the first time, the MAG welcomed commercial as well as educational exhibits. The expanded exhibit area allowed attendees to review the products and services of a wide range of firms. One of the new displays was that of the MAG Mutual Insurance Company, which has been chartered by the state and licensed to raise $3 million in surplus funds. Mr. Howard Lamb, Executive Vice President of MAG Mutual, addressed several specialty meetings, informing physicians that the Company is indeed "off and running."



Dr. C. Daniel Cabaniss of Columbus, Chairman of the MAG Education Committee, introduces the five speakers at the MAG Conference on Medical Education held Thursday, November 19, 1981, at the Omni International Hotel in Atlanta.

On the day before the Assembly, the MAG sponsored a Conference on Medical Education. Over seventy physicians and medical students gathered to hear the deans of the state's medical schools and allied health training programs address the subject of preparing health care professionals for future patient care. Dr. C. Daniel Cabaniss of



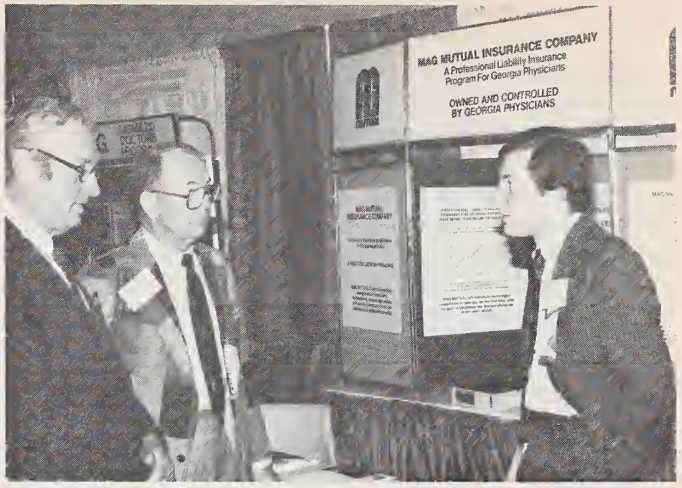
Dr. Cabaniss introduces the speakers for the Medical Education Conference: (r-l) Dr. James F. Glenn of Emory University Medical School; Dr. Fairfield Goodale of MCG; Dr. Louis A. Sullivan of Morehouse Medical School; Dr. William Bristol of Mercer University School of Medicine; and Dr. J. Rhodes Haverty of the Georgia State College of Health Sciences.



Chatting near the registration desk are (l) Dr. Edwin C. Evans of Atlanta, President of the Southern Medical Association, and Dr. Milton Frank, III, President of the Georgia Society of Internal Medicine. Dr. Evans has directed planning for next year's joint MAG-SMA Scientific Assembly.



Dr. Charles D. Hollis, Jr., President of MAG Mutual Insurance Company, and President-elect of the MAG, describes the company's progress to attendees of the Georgia Society of Internal Medicine luncheon held on November 20.



MAG Mutual Insurance Company was one of the firms exhibiting at the Scientific Assembly on Friday and Saturday. Here (l-r), Dr. J. Harold Harrison and Dr. Carson B. Burgstiner of Savannah hear about the company from Mr. Bert Franco of the MAG staff.

Columbus, Chairman of the MAG Education Committee, introduced William Bristol, M.D., of Mercer; James F. Glenn, M.D., of Emory; Fairfield Goodale, M.D., of the Medical College of Georgia; J. Rhodes Haverty, M.D., of the College of Health Sciences at Georgia State; and Louis W. Sullivan, M.D., of Morehouse School of Medicine.

Next year's Scientific Assembly will be cosponsored by the Southern Medical Association and the Medical Association of Georgia. Scheduled for October 31-November 3, 1982, the SMA-MAG meeting will be held at the World Congress Center. These plans represent the second time in which the SMA will have held its Scientific Assembly with that of the MAG, and once again several thousand physicians are expected to attend.

C. Rex Teeslink, M.D., of Augusta will serve as chairman of both the MAG Scientific Assembly Committee and of the SMA Committee on Scientific Work. Coordination between the two Associations will be further helped by Edwin C. Evans, M.D., of Atlanta, President of the Southern Medical Association and past chairman of the MAG Education Committee. Program arrangements are well underway, and you will receive our Preliminary Program in August.

(Reported by Stephen Davis, Director of Education, MAG.)

MAG Mutual Is Waiting for *You*

MAG Mutual Insurance Company began the sale of Surplus Certificates in late November, 1981. Physicians from throughout Georgia have expressed their support for MAG Mutual by sending in their $1500. Many more have voiced their support but have not yet returned their Subscription Agreements and checks. This may be because they are waiting for their current policies to expire. They must not wait, however. The Company must raise the minimum capitalization before it can begin writing policies.

Each MAG member was mailed a packet describing MAG Mutual's program to bring competiton and stability into Georgia's professional liability market. Now is the time to take this action designed to give physicians control over their professional practice.

While we have made considerable progress in our fundraising efforts, our goal of $3,000,000 in initial capitalization has not been reached. The Board of Directors and Officers of MAG Mutual urge you to act *today* by mailing your $1500 and Subscription Agreement to MAG Mutual. This is your opportunity to play an active part in your professional liability insurance program.

Georgia Doctors and Their Families

Are you a descendant of one of the doctors named below? Have you carried on the tradition of the practice of medicine begun by someone in your family?

The Research and Romance of Medicine Committee of the Auxiliary to the Medical Association of Georgia is collecting the biographies of our dedicated physicians of the past which we plan to have bound and preserved for posterity. We have biographies of the 19th century physicians listed below, and we would welcome any information of interest about them or their descendants, especially those who have continued in the medical professions.

Please forward any information about the following doctors to Mrs. William H. Benson, 1099 Burnt Hickory Rd., Marietta, GA 30064.

James F. Alexander
William Simpson Armstrong
James Bozeman Baird
Charles F. Benson
William D. Bizzell
Joseph Wenger Blosser
Abner Wellborn Calhoun
Julius Arthur Childs
Elijah Lewis Connally
Hunter Pope Cooper (May be Hunter D.)
Walter Andrew Crowe
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John Wesley Duncan
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James McFadden Gaston
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Charles Davis Hunt
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William Calvin Jarnagin
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John Thaddeus Johnson
William S. Kendrick
James Jerrold Knott
Joseph Payne Logan
William Abram Love
Floyd Willcox McRae
Manning Willis Manahan
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Henry Michel
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George H. Noble
John Cooke Olmsted
Francis Hodgson Orme
Willis B. Parks
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Gustavus Garnett Roy
Henry Fort Scott
Valentine H. Talizferro
James Scott Todd
John G. Westmoreland
Willis J. Westmoreland, Jr.
William H. White
Henry L. Wilson
Bernard Wolff

Georgia Agrirama — Tribute to Early 1900s' Heritage

Mrs. William H. Benson (Peggy), of Cobb County, Chairman of the Research and Romance of Medicine Committee of the Auxiliary to MAG, has challenged auxiliary members to help in recording each county's history of medical pioneers.

"The story of Georgia doctors — their daily lives, their medical science, their other endeavors in their communities is yet to be told," she says.

When this work is completed, copies of biographies of Georgia's physicians of the past will be filed for safekeeping in several places about the state. One of these depositories is the Georgia Agrirama in Tift County, where developers are attempting to tell the story of rural doctors and to preserve and exhibit their heritage along with that of pioneers in other fields.

Already, the old office building once used by Dr. Henry A. Vann (1850-1933), of Boston, Ga., has been obtained and moved to the site of the Agrirama, which is just off Interstate-75 on the northern edge of Tifton. It is to be restored to its original appearance and furnished with equipment in the style typical of the post-Civil Wars years. The biographies of Dr. Vann and other Georgia physicians will become a part of this restoration.

According to a framed document attached to the wall beside the front door, the building originally was used by Mr. Daniel A. Horn as a sawmill and cotton gin office. The completed exhibit is planned as a fitting tribute to the labors of Dr. Vann and his colleagues in the medical profession.

The physician's role changed little in the years before 1900, explains the document, but his practice gradually centered in the growing railroad towns. In these locations, two or more doctors frequently opened offices, some in their homes or their drug stores, and others in upstairs rooms or small buildings.

In the sparsely-populated Georgia wiregrass region of the 1900s, the local doctor was considered an important figure. He was the final resort in an era when such dread diseases as typhoid, malaria, and yellow fever were rampant, and even minor injuries could prove fatal. He was usually surgeon, druggist, dentist, and perhaps undertaker, as well as physician for patients scattered over a wide area. Much of his practice was devoted to house calls. Without his diligent service, the developers have found, the hazards of life in this region would have been greater than they were.

The old building has taken its place in the midst of much nostalgia where, among other things, visitors may tour several homes of the bygone period, see corn ground into grits and meal, watch a newspaper being printed on an antiquated machine, attend church services where an old pump organ welcomes them to worship, ride a steam-powered train, see resin gathered to make turpentine, and observe the sawing of logs into boards at an authentic sawmill.

(Reported by Mrs. Brit B. Gay, Jr. (Evelyn), AMAG)

Update on the "Battle of the Budget"

The Reagan Administration is forging ahead with its plan to slash 12% from domestic federal programs despite mounting Congressional resistance. A complicated budget battle is engulfing the Capitol with the latest wrinkle — a decision by President Reagan to defer some $1 billion in spending while Congress deliberates the issue of a new round of cuts.

At present, all federal agencies are operating under a stop-gap continuing resolution to keep them funded. Only 12 major appropriations bills to provide money for the current fiscal year that started October 1 have been adopted by Congress. The House has passed 10 bills; the Senate, two. Most of the appropriations bills reflect the $30 billion of savings called for in the massive budget reconciliation measure approved by Congress last August.

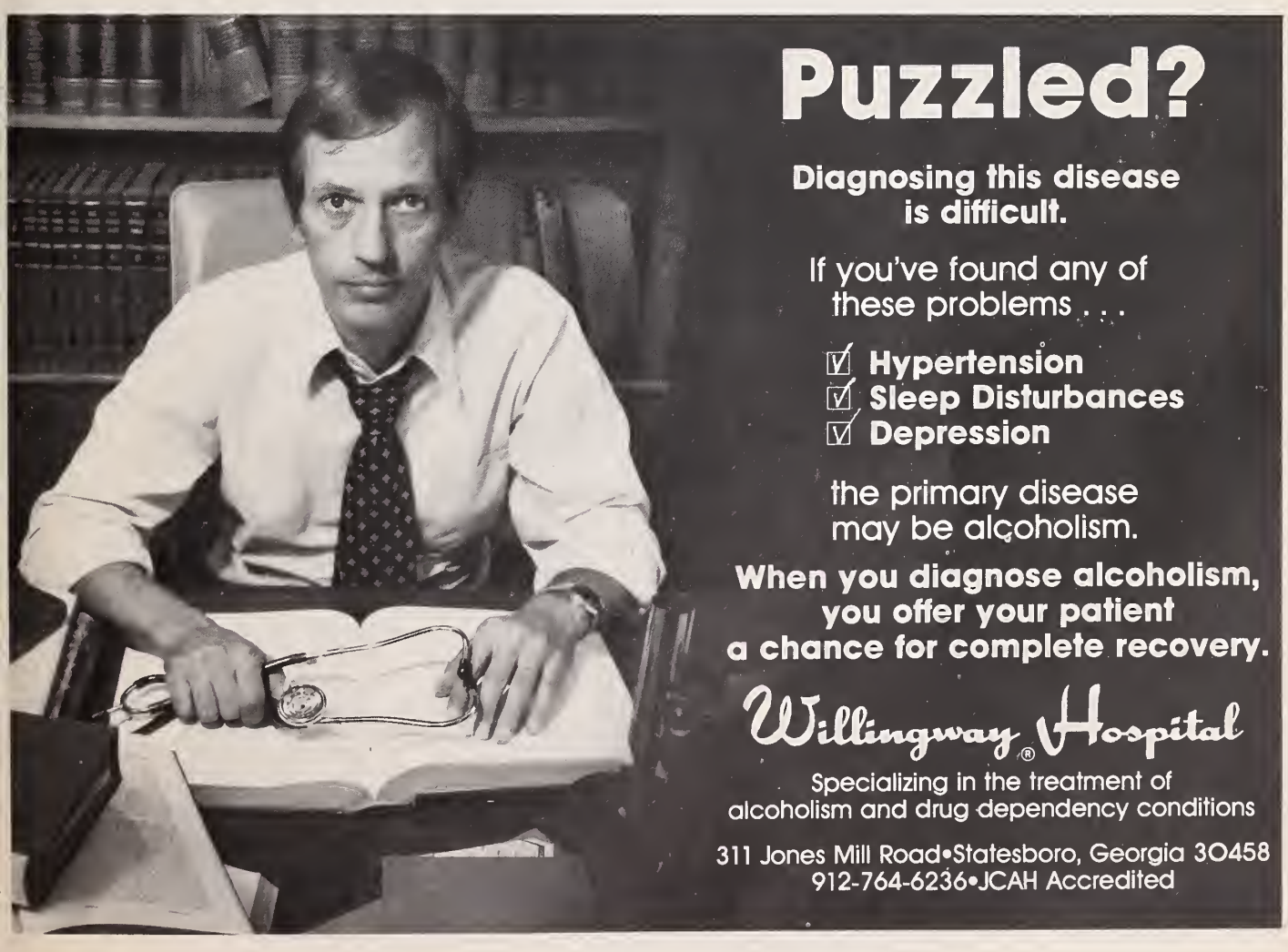
There has been no action by Congress, however, on the President's recent proposal to pare another $13 billion from federal spending during the current fiscal year. This would involve an extra $1 billion taken from federal health program expenditures.

An indication of the difficulties facing the Administration came in the House vote on the Health and Human Services (HHS) Department appropriations bill when a move to send the bill back to committee to make further cuts as requested by the President was defeated 249 to 168.

The President's plan to defer spending by $1 billion from the initial period would temporarily reduce spending for 500 to 800 domestic programs below the stop-gap rate set by Congress. Authority for such deferrals come from the 1974 Budget Act. House Speaker Thomas O'Neill charged the tactic is "a backdoor method to frustrate the law."

The next months promise to pose stern confrontations between Congress and the Administration on the spending issue which will dominate the domestic scene through the rest of the session. Presidential vetoes of over-the-mark appropriations bills already have been threatened.

(From "The Month in Washington," Oct. 30, 1981, AMA Washington Office.)



MEDICAL MEETING CALENDAR

JANUARY

16-21—*Virgin Islands:* **Gynecologic Surgery.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

18-22—*Innisbrook, FL:* **Radiology for the Non-Radiologist.** Category 1 credit. Contact Edward A. Eikman, MD, Univ. of S. Fl. College of Med., 12901 N. 30th St., Tampa, FL 33612. PH:813/974-2032.

20-23—*Lake Buena Vista, FL:* **Clinical Immunology: Update for the Practitioner.** Contact Univ. of Fl. College of Med. — CME, Box J233, JHM Health Ctr., Gainesville, FL 32610. PH:904/392-3143.

22-23—*Atlanta:* **Pediatric Ultrasound.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

27-31—*Atlanta:* **Pediatric Cooperative Course.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

FEBRUARY

1-5–Snowmass, CO: **Sixth Annual Conference on Pain, the General Practitioner, and the Science of Algology.** Category 1 credit. Contact Office of Cont. Ed., Ctr. for Rehab. Med., Emory Univ. Sch. of Med., 1441 Clifton Rd., NE, Atlanta 30322. PH:404/329-5507.

4-6—*Sanibel Island, FL:* **Hypertension 1982: Practical Management Considerations for the Physician in Clinical Practice.** Category 1 credit. Contact Dept. of Ed., Amer. College of Chest Phys., 911 Busse Hwy., Park Ridge, IL 60068.

5-6—*Gainesville, FL:* **Second Symposium on Burn Care.** Category 1 credit. Contact Univ. of Fl. College of Med. — CME, Box J233, JHM Health Ctr., Gainesville, FL 32610. PH:904/392-3143.

11-12—*Augusta:* **Clinical Pathology.** Category 1 credit. Contact Div. of Cont. Ed., MCG Sch. of Med., Augusta 30912. PH:404/828-3967.

12-13—*Atlanta:* **Myths and Realities of Learning Disabilities.** Cosponsored by Emory Univ Sch. of Med. Category 1 credit. Contact Conference Coordinator, The Barclay Sch., 385 Mt. Paran Rd., NW, Atlanta 30327. PH:404/256-2470.

12-14—*Atlanta:* **Georgia Psychiatric Association — "Changing Women."** Category 1 credit. Contact Sarn B. Brown, M.D., 3280 Howell Mill Rd., NW, Atlanta 30307. PH:404/351-2330.

13-20—*Keystone, CO:* **Seventh Annual Snowjob in Gynecology and Obstetrics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

17-22—*New Orleans:* **Second Annual Multidisciplinary Microsurgery at the Mardi Gras Symposium.** Cosponsored by LSU Med. Ctr. & Southern Bapt. Hosp. Contact Chev Hahn, Southern Bapt. Hosp., 2700 Napolean Ave., New Orleans, LA 70115. PH:504/897-5911.

22-27—*Augusta:* **Seventeenth Annual Family Practice Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-28—*Augusta:* **Anesthesiology and Acute Medicine — Annual Meeting of the Georgia Society & South Carolina Society of Anesthesiologists.** Category 1 credit. Contact C. F. Johnson, Jr., M.D., Dept. of Anesth., MCG, Augusta 30912. PH:404/828-3871.

MARCH

2-5—*Durango, CO:* **Fifth Annual Symposium on Emergency Medicine — Trauma.** AMA Category 1 and AAFP prescribed credit. Contact Gerald T. Chambers, Ph.D., Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

12—*Gainesville, FL:* **Symposium on Glaucoma: Patient Evaluation, Surgical and Laser Therapy.** Contact Univ. of Fl. College of Med., J233 JHM Health Ctr., Gainesville, FL 32610. PH:904/392-3143.

18-20—*Gainesville, FL:* **13th Annual Topics in Internal Medicine.** Category 1 credit. Contact Univ. of Fl. College of Med., Box J233, JHM Health Ctr., Gainesville, FL 32610. PH:904/392-3143.

19—*Columbus:* **Carcinoma of the Breast, Ovary, and Endometrium.** Category 1 credit. Contact Shirley S. Preston, American Cancer Society, 1422 W. Peachtree St., Atlanta 30309. PH:404/892-0026.

24-26—*Atlanta:* **Current Concepts in Pediatric Ophthalmology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

26-27—*Callaway Gardens:* **Geriatric Conference for Primary Care Physicians.** Category 1 credit. Contact Michael C. Sims, M.D., Dept. of Fam. Pract., P.O. Box 7216, Columbus 31908-7216. PH:404/571-1133.

APRIL

1-3—*Atlanta:* **Emory Medical Alumni Conference.** Contact Alumni Office, Emory Univ., Atlanta 30322. PH:404/329-6199.

2-4—*Atlanta:* **Second Annual Atlanta Eye Congress.** Category 1 credit. Contact Ms. Ginger Lineberger, 3280 Howell Mill Rd., NW, Ste. 207, Atlanta 30327. PH:404/351-2713.

5-7—*Atlanta:* **Pediatrics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Atlanta:* **"Starting Your Practice" Seminar for Residents.** Cosponsored by AMA & MAG. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224.

15-17—*Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

17-18—*Atlanta:* **Hemodynamic Monitoring.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE., Atlanta 30322. PH:404/329-5696.

20-24—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-25—*Williamsburg, VA:* **Fourth Annual Conference on Emergency Medicine for the Primary Care Physician.** AMA Category 1 and AAFP prescribed credit. Contact Glenda L. Snow, Office of CME, Med. College of Va., Box 48, MCV Station, Richmond, VA 23298. PH:804/786-0494.

24-25—*Augusta:* **Disease Prevention and Health Maintenance.** AMA Category 1 and AAFP prescribed credit. Contact Gerald T. Chambers, Ph.D., Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.


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Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerotomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipatian, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large averdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets	NDC 0524-0058-01
Bottles af 500 Tablets	NDC 0524-0058-05

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DESCRIPTION

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Phenylephrine Hydrochloride	30
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Alcohol	

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expe torant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upp respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rh tis. Also, for the temporary relief of symptoms associated with hay fever, allergies, na congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an o hypertensive or antidepressant drug containing a monoamine oxidase inhibitor contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma o in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient sho be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant m cause drowsiness. Patients should be warned of the possible additive effect caused taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle operating dangerous machinery (See Warnings). Caution should be taken with patie having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddine dryness of mucous membranes, tightness of the chest, thickening of bronchial secretio urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, foi ness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xer stomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric d tress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessne excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and ev convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoontuls, orally, every 4 hours, not exceed 10 teaspoontuls in any 24-hour period.

Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoontuls in a 24-hour period. Children 2 to 6 years of age: ½ teaspoontul every 4 haurs, not exceed 3 teaspoontuls in any 24-hour period. Children under 2 years of age: Use directed by a physician.

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The Impact of the Reagan Administration on Office-Based Physicians

T. REGINALD HARRIS, M.D., *Shelby, North Carolina**

BEFORE DISCUSSING some of the specifics of the Reagan Administration's health care policies and their potential impact, I would like you to take a minute and imagine yourself five years from now at the Medical Association of Georgia's 1986 annual meeting:

Congress eliminated the authorizing legislation for health systems agencies in late 1982. HSAs no longer exist. ''Pro-competition'' legislation — which enables most employees to opt for the least expensive insurance policy — finally was approved in early 1984. The option of selecting among several insurance policies seems to have worked well for most of your patients, but you're worried about several who are inadequately covered. And you continue to worry about the increasing numbers of doctors — and allied health personnel — lured to the South by the weather and the thriving economic climate. How did these changes happen? Perhaps a look at what's going on now will help us understand how we can shape these trends.

I would like to focus on three areas of intense interest in Washington right now — regulations and regulatory programs, transfer of the ''health care dollar'' from the federal government to the states, and ''pro-competition'' legislation.

Regulations

One of President Reagan's most-publicized initial acts of office was to promulgate a 60-day freeze on federal regulations. The Federal Register did not cease publication — or even reduce its size substantially — as a result, but his action set the stage for the fate of several health-related programs, including health planning, PSROs, and HMOs.

First, two recent Congressional actions affected health systems agencies, which originally were set up under the National Health Planning and Resources Development Act in late 1974. Last month, the House of Representatives approved an $87 million appropriation — of which $50 million has been targeted for HSAs — for fiscal year 1982. This amount is higher than the Administration's request and may be subject to further cuts. The Omnibus Reconciliation Act of 1981 also changed the program in several important aspects and extended it through 1982. The act specifically:

—raised the threshhold of expenditures subject to review by planning agencies from $150,000 to $600,000 for capital outlays; from $150,000 to $400,000 for major medical equipment; and from $75,000 to $250,000 for the annual operating costs of new services;

—authorized governors to request elimination of federal funding of HSAs in their states if they certify that state health planning agencies will assume the HSAs' functions. The State of Ohio already is following this model and has asked for elimination of HSAs in Ohio;

—approved a 1-year extension for states to enact certificate of need (CON) legislation or face penalties.

* Dr. Harris is Secretary-Treasurer of the American Society of Internal Medicine. He delivered this address at the luncheon sponsored by the Georgia Society of Internal Medicine at the 1981 MAG Scientific Assembly in Atlanta. His address is 808 Schenck, Shelby, NC 28150.



T. Reginald Harris, M.D., addressing the Georgia Society of Internal Medicine.

The American Society of Internal Medicine (ASIM) House of Delegates recently approved a policy supporting local, voluntary planning in place of the expensive and cumbersome HSA mechanism. We have been working with other groups to gather support for a bill introduced by Congressman Shelby which would repeal authorization for the federal program by the end of fiscal year 1982. Elimination of federal funding — without repeal of the authorizing legislation — would leave sanctions intact which can be imposed on states without CON statutes on their books. Without repeal, such states will lose their Public Health Service appropriations — even if no federal funds have been allocated for health planning.

The PSRO program — targeted by the Administration for extinction — also escaped a House Ways and Means Committee provision advocated by Rep. Crane of Illinois that would have repealed both the program's authorizing legislation and the Medicare requirement for utilization review. Instead, Congress voted to streamline the program. Under the Reconciliation Act, the DHHS Secretary is authorized to terminate 30% of the nation's local PSRO programs by Sept. 30, 1982 — in addition to those already eliminated by last year's cuts. The federal government also will provide a 75% matching grant to states which use PSROs for Medicaid claim review.

At its recent meeting, the ASIM House of Delegates strongly supported "voluntary, physician-directed peer review programs which are dedicated to upholding quality medical care." The House also approved a set of guidelines that peer review programs should fulfill, including the importance of physician-direction, coordination with other quality assurance programs, medical record confidentiality, and most importantly, appropriate emphasis on quality rather than cost."

The third federal program of interest to physicians involves HMOs. Federal support of many HMOs has made meaningful comparisons with other forms of health care delivery more difficult. This support has provided HMOs with an unfair competitive advantage and has hidden the fact that the three largest HMOs in this country were developed from private funds. In keeping with the Administration's plans for increased private sector involvement, the House Appropriations bill reduces federal funding for the HMO program during fiscal year 1982. The federal government will negotiate with potential private investors about the amount of an HMOs' indebtedness to the government.

"Health Care Dollar"

The second major focus of federal activity involves transferring cost from the federal to the state governments in order to reduce the amount of federal funding for the two largest entitlement programs — Medicare and Medicaid.

The administration originally had proposed that federal funds previously earmarked for special categories, such as drug abuse, alcoholism, and mental health, be assigned to one of four major categories and awarded to the states as "block grants." States would be permitted to award the funds within each block to the locally-determined appropriate program. An across-the-board cut in expenditures was proposed simultaneously. Congress balked at some of the Administration's recommendations and permitted much greater federal restrictions on state use of funds within the grants. But total federal spending on health programs was reduced approximately 25% and another $1 billion in federal savings is expected from cuts in the federal government's share of Medicaid.

"Pro-competition" proposals are based on a revised tax structure intended to restrain medical care costs while providing effective insurance coverage.

The Medicaid and Medicare programs deserve an additional word. Although Congress defeated an Administration attempt to "cap" or place a maximum limit on Medicaid expenditures, a 3-year reduction plan was approved. Under this method, Medicaid expenditures must be 3% less than what they would have been in 1982; 4% less in 1983; and 4.5% less in 1984. In return, the states have additional flexibility to administer the program, including:

—competitive bidding for the purchase of medical and laboratory services;
—requiring "chronic overusers" of services to see a single physician;
—imposing "reasonable charge limits" for physician services.

Despite the potential political backlash, Congress also implemented some cost-saving mechanisms in the Medicare program. The 1981 Reconciliation Act increased the Part B deductible from $60 to $75 annually, eliminated a provision which permitted carry-over of the previous year's medical expenses to satisfy the current year's deductible, and did away with unlimited open enrollment.

"Pro-Competition Proposals"

Perhaps the phrase "pro-competition" has generated more confusion about terminology than anything else. Used specifically in the context of the recent congressional debate, "pro-competition" proposals are based on a revised tax structure intended to restrain medical care costs while providing effective insurance coverage. The bills introduced by Congressman Gephardt and former Congressman Stockman and Durenberger and Hatch on the Senate side all share some common features;

—First, they would change tax code provisions relating to employer contributions for employee health benefits;
—Second, they would mandate certain minimum benefit requirements for all health insurance programs;
—Third, they would require large employers to offer employees three or more health plan options and fix the employee's level of contribution regardless of the option selected.

The Administration is expected to introduce its own "pro-competition" proposal before the end of the year.

The DHHS Secretary is authorized to terminate 30% of the nation's local PSRO programs by Sept. 30, 1982.

In a statement last month before the House Ways and Means Subcommittee on Health, ASIM Trustee Dr. N. Thomas Connally told the Committee that the fundamental concept of the "pro-competition" proposals — that employees be offered a choice among several health plans — is consistent with ASIM's support of a pluralistic health care system. ASIM emphasized that the proposed legislation should restrain medical care costs, but not sacrifice high quality patient care. "Pro-competition" legislation must also:

—expand the patient's free choice of competing health insurance plans;
—require reasonable co-payments by patients;
—protect the patient's free choice of physician;
—require equal employer contributions to all sponsored plans including tax-free payments to employees who opt for less expensive coverage;
—limit employers' deductions for their contributions for health insurance coverage;
—prevent disproportionate selection or "skimming" of patients;
—minimize regulation of health care insurance and delivery systems, except where necessary to protect the public;
—require minimum coverage provisions, including insurance for catastrophic illness and physicians cognitive services;
—provide for coverage of the unemployed and high-risk populations.

What does this combination of factors — a different approach to regulation, transfer of funds to the states and "pro-competition" proposals — mean to us as practicing physicians and to the organizations which represent us?

While speculation about the future is always tenuous, I'd like to return to my opening scenario for a minute. One probable effect of a more competitive health care system will be an increase in turf battles among the various specialties. If physicians are forced to compete for patients and limited health care dollars more than in the past, it seems inevitable that disputes among the specialties will happen more often. ASIM and other specialty societies will play an increasingly important role. Because ASIM has been the internist's advocate in the socio-economic arena for the past 25 years, I think the organization is well suited for this function. However, ASIM will use careful negotiation — rather than open confrontation — to protect the internist's turf. We strongly believe that medicine must remain united although we recognize that disagreements among the various elements of organized medicine will occur.

ASIM and other segments of organized medicine must function as watchdogs in a competitive environment. Competition may have many benefits. But low quality, "bargain basement" medicine may result if competition is based on price factors alone. As physicians, we must reserve the right to object to competition which lowers the quality of care provided to our patients.

Another impact of the Reagan Administration's approach will be to increase state influence on health care policy. Specialty societies with a strong component society structure and good working relationships with their state medical associations will be in a better position to influence decisions on a state level. Because ASIM has many strong component societies — like the Georgia Society of Internal Medicine — we will be able to capitalize on the growing role of state governments.

The third effect will be additional pressure on the private sector to restrain health care costs. President

Reagan is gambling that the private sector can do a better job of restraining costs than the government has.

To meet the challenge, however, we must make a truly collaborative effort with the recipients of our services — our patients. The "pro-competition" proposals and the transfer of Medicare/Medicaid resources are designed to give patients a vested interest in using the "health care dollar" as wisely as possible. This works by transferring some of the monetary burden from employers — and the federal government — to the individual. It is hoped, but remains to be seen, that this transfer will have a secondary effect of restraining medical costs.

Much of the debate about medical costs and "private sector initiative" really masks a deeper social issue which must be resolved rather than attacking the problem piecemeal. Society must determine its priorities and decide how much of its assets should be devoted to medical care. It is the old "guns and butter" argument, and unfortunately, we simply do not have enough resources to provide everything for everyone. As physicians and citizens, we must participate in the debate, but we cannot act as final arbiters. Nor can we bear sole responsibility for the problems generated by the "system" which we are now facing.

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Various local factors in addition to sun exposure are thought to contribute to the development of basal cell carcinoma.

Georgia's Most Common Skin Cancer: Basal Cell Carcinoma

KIM B. YANCEY, M.D., *and* MARSHALL A. GUILL, M.D., LTC, MC, *Fort Gordon**

More cancers occur on the skin than at any other anatomical site.[1] Basal cell carcinoma (BCC), the most common form of skin cancer, arises from the basal area of the epidermis, only rarely metastasizes, but does exhibit true local malignant behavior.[2]

Developmental Influences and Incidence

The single most important causative factor in the development of BCC is exposure to sunlight.[1, 2] Darker races are much less susceptible than are Caucasians. In a recent review of 18 cases of BCC in North American black patients, however, all lesions except one were in sun-exposed areas of the head and neck.[3] Individuals with light hair, blue eyes, and fair complexions which sunburn easily are especially prone to BCC.[4] Although the prevalance of BCC parallels cumulative sun exposure, the cutaneous distribution of lesions does not exactly correlate with areas of maximal solar irradiation.[5] For example, BCC are common on the eyelids, the nasolabial folds, the inner canthi, and in the posterior auricular region; whereas, occurrence on the dorsum of the hand or vermillion border is rather infrequent.[1, 6] For these reasons, various local factors in addition to sun exposure are thought to contribute to the development of BCC.[6] Certainly, local influences play a role in those cases of BCC which arise in adnexal hamartomas such as nevus sebaceous.[7] Other situations in which BCC may develop include burn scars, vaccination scars, or skin damaged by ionizing radiation.[7]

BCC is more frequent in males than females; as mentioned previously, lesions in dark-skinned races are rare.[2, 5, 6] Although BCC usually occurs in patients over 40 years of age, it also occurs in young adults.[2] A person with BCC is at increased risk for additional lesions.[2, 6] Lesions in children are usually restricted to those with an inherited predisposition to cutaneous neoplasms, e.g., the nevoid basal cell carcinoma syndrome, xeroderma pigmentosum.[1, 2]

Types of BCC

Numerous types of BCC exist. The major ones are: nodulo-ulcerative, superficial, morphea, and pigmented. Each type of BCC has rather characteristic features, some of which are common to several lesions.

The nodulo-ulcerative BCC is the most common variant and is characterized by the classic cliches applied in textbook descriptions.[2] The lesion begins as a papule or plaque with a waxy/pearly border crossed at several sites by telangectatic blood vessels. As the lesion enlarges the central portion undergoes ulceration which expands coincident with the growth of the cancer (Figure 1). Advanced nodulo-ulcerative BCCs become classic rodent ulcer-type sores.[7]

The superficial BCC is characterized by an erythematous plaque with associated scaling, crusting, and occasional atrophy and scarring (Figure 2). These lesions also demonstrate a fairly sharp margin with an elevated and rolled pearly border. Deep central ulceration in superficial BCC is uncommon.

* Drs. Yancey and Guill are from the Department of Dermatology, Medical College of Georgia, Augusta, and Eisenhower Army Medical Center, Fort Gordon. This article represents the private views of the authors and are not to be construed as official or as reflecting the views of the Department of the Army or the Department of Defense. Address reprint requests to Dr. Guill, Eisenhower Army Medical Center, Fort Gordon, GA 30905.



Figure 1 — Nodulo-ulcerative BCC has a waxy/pearly border crossed by telangectatic blood vessels.

In contrast to nodulo-ulcerative BCC, these lesions are predominantly located on the trunk.[1, 2, 7]

Perhaps the most subtle and deceptive BCC is the morphea type. This lesion develops as an indurated plaque with associated telangectasia and atrophy. The skin in a morphea-type BCC may remain free of ulceration for a considerable period.[7] The margins of these lesions are quite indistinct and must be defined on treatment.[2]

The pigmented BCC demonstrates all the features of a nodulo-ulcerative lesion plus a deep hyperpigmentation (Figure 3). Variable colors may be present within a pigmented BCC; a biopsy is often required to differentiate such lesions from melanoma.[1, 5] A useful clinical aid in differentiation of these two skin cancers is that solidly pigmented dark brown or black malignant skin lesions in patients with blue, gray, or green eyes are more likely to be melanoma than BCC.[8]

Other less common types include the cystic BCC, the fibroepithelioma of Pinkus, and the nevoid lesions seen in the nevoid-BCC syndrome.[7] However, greater than 95% of BCC conforms to the description of the common types previously mentioned. Recognition and appropriate treatment of these skin cancers will avoid undue complications.

Complications

The most common complication of BCC is local destruction by untreated or inadequately treated



Figure 2 — Superficial BCC is characterized by an erythematous plaque with associated scaling and crusting.

lesions.[1, 2, 5] Disfigurement results when lesions perforate the nares, invade the sinuses, destroy the orbit, or other facial structures. Invasion of extraocular muscles by BCC often requires enucleation for adequate treatment. In rare instances, advanced BCC may invade the facial bones, the skull, and even the meninges. Death from such progressive involvement has been reported.[6]

BCC only rarely metastasizes. A review published in 1974 found fewer than 100 cases of metastatic BCC in the literature.[9] Lesions resulting in disseminated disease usually are large cancers of many years duration which have been refractory to several treatment attempts.[7] Metastatic foci of BCC are usually limited to the regional lymph nodes; when visceral involvement has occurred, preferential sites include the lungs, pleura, liver, and bone.[7] Host factors probably play a role in advanced BCC which metastasizes, since this lesion is ordinarily dependent on dermal stroma for survival.[5, 7, 10]

Recently, a subset of patients with an increased rate of complication due to skin cancers has been defined. Patients with chronic lymphocytic leukemia and lymphocytic lymphomas experience more numerous and aggressive BCC and squamous cell carcinoma than normal age-matched controls.[11] Furthermore, several case reports reveal episodes of metastasis of squamous cell carcinoma in these patients;[11, 12] in some instances, the metastatic disease proved fatal.[12] Basal and squamous cell carcinomas should be carefully handled in patients with lymphocytic neoplasms.

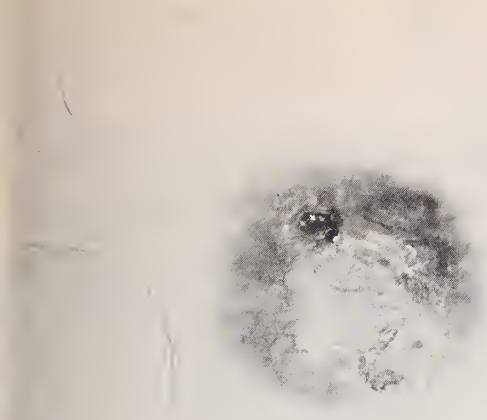


Figure 3 — Pigmented BCC demonstrates a deep hyperpigmentation.

Treatment

Treatment of basal cell carcinoma is directed toward eradication of the tumor with the most acceptable cosmetic result. Various modalities of therapy available include excisional surgery, cryosurgery, currettage and electrodessication, radiation, application of cytotoxic agents, and chemo or microscopically controlled surgery. Definitive treatment is best attempted after a shave biopsy of the lesion confirms the diagnosis and reveals the histologic type of BCC. Morphea BCC is often more difficult to treat, since clinical margins may be indistinct. Some degree of expertise and experience is required in choosing the therapeutic modality that is curative with the most acceptable cosmetic results. Microscopically controlled surgery or chemosurgery is the treatment of choice for recurrent BCC or those with indistinct margins.[5, 6]

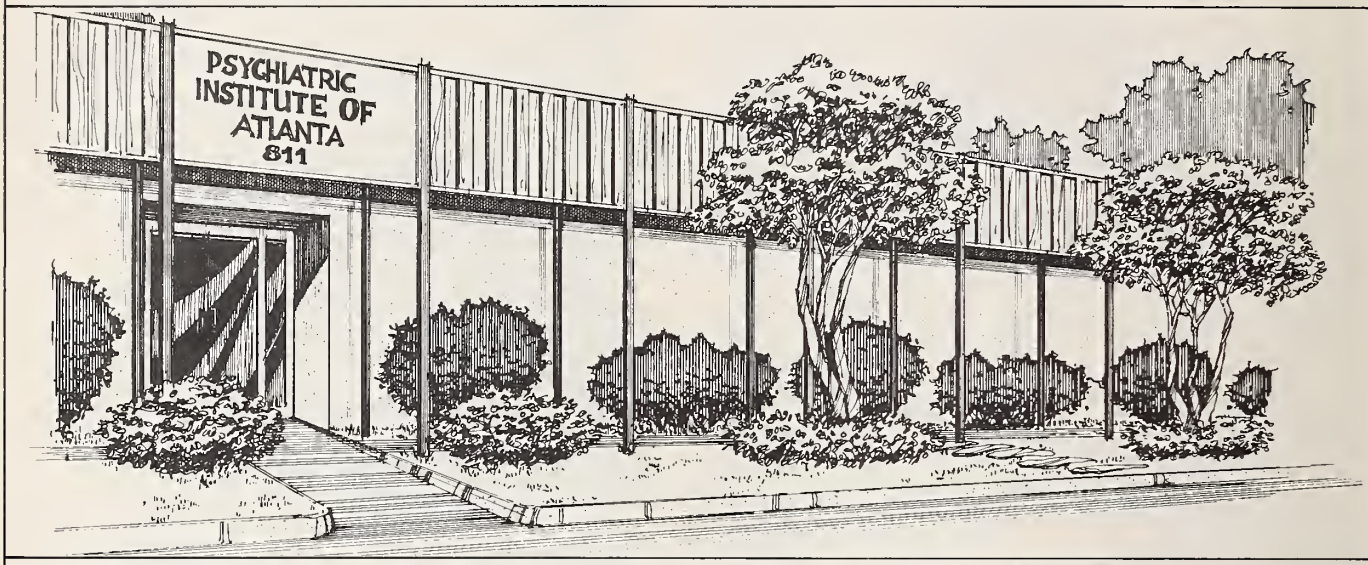
As with other types of cancer, long-term follow-up of patients with BCC is advised. Persons who have sustained sufficient sun exposure to cause one BCC are more likely to have others. The use of sunscreens and avoidance of unnecessary sun exposure should be stressed as preventive measures.[5, 6]

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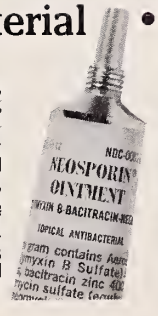
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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

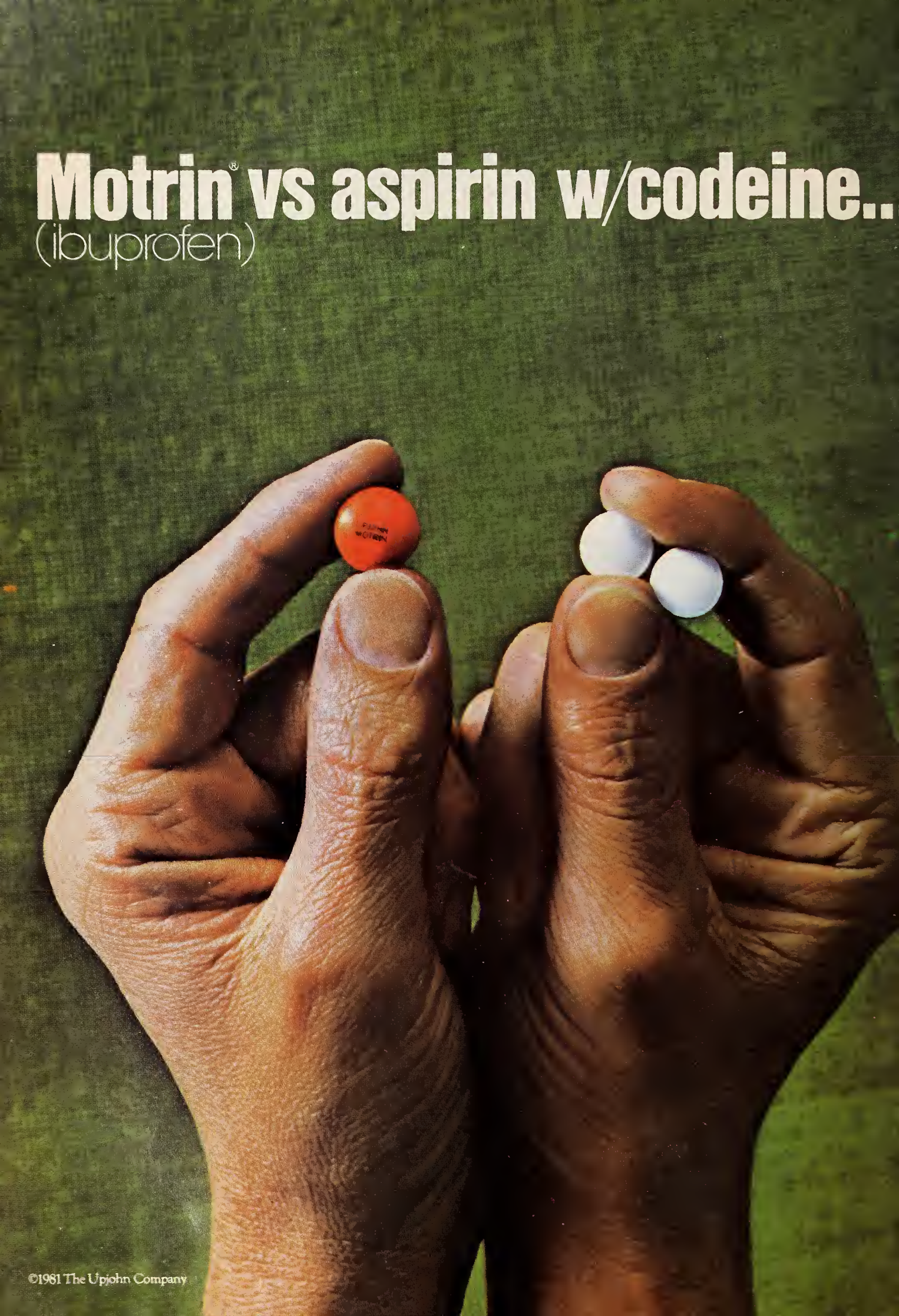
PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Motrin® vs aspirin w/codeine..
(ibuprofen)

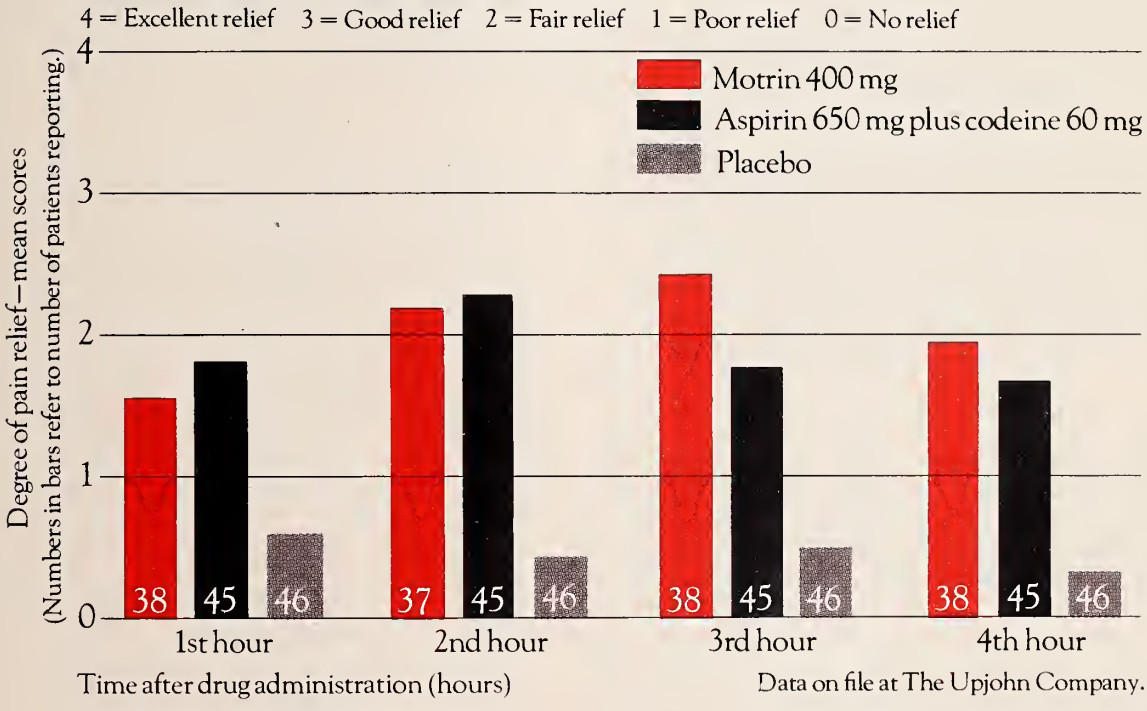


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compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

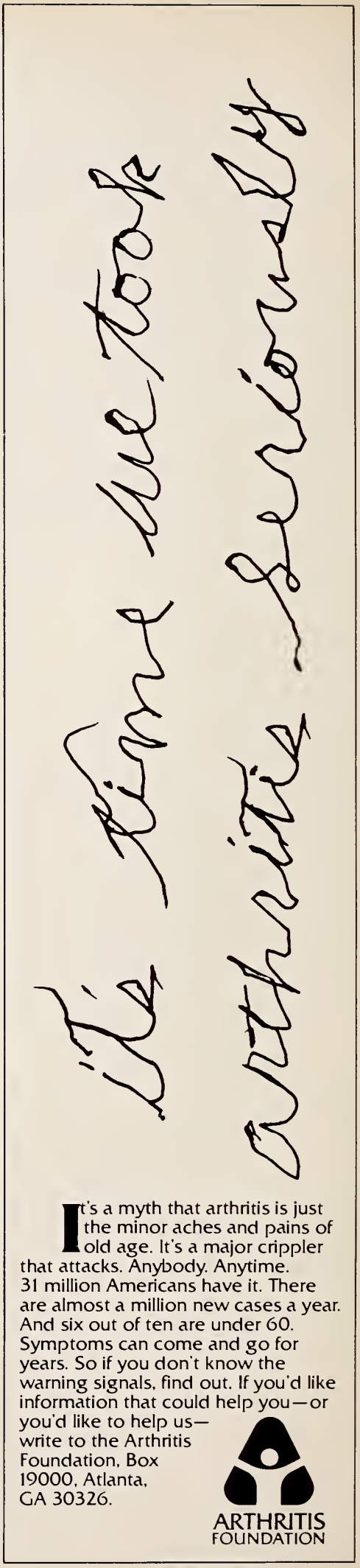
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MARCH 1981



It's a myth that arthritis is just the minor aches and pains of old age. It's a major crippler that attacks. Anybody. Anytime. 31 million Americans have it. There are almost a million new cases a year. And six out of ten are under 60. Symptoms can come and go for years. So if you don't know the warning signals, find out. If you'd like information that could help you—or you'd like to help us—write to the Arthritis Foundation, Box 19000, Atlanta, GA 30326.

ARTHRITIS FOUNDATION

The purpose of this paper is to explain the rationale for nutritional assessment in carefully selected hospital patients.

Nutritional Assessment: Clinical and Biometric Measurements of Hospital Patients at Risk

KENNETH H. COHN, M.D., *and* GEORGE L. BLACKBURN, M.D., Ph.D., *Boston**

Recently, the importance of adequate nutrition in hospitalized patients has become recognized because of its effect on the outcome of disease processes. Bistrian et al.[1] reported not only that the prevalence of protein-calorie malnutrition in a city hospital was 40% but also that malnourished patients suffered a seven-fold increase in mortality. The malnutrition described by Bistrian differs from the nutritional deficiencies seen in developing nations, because malnutrition in hospitalized patients results from inadequate oral intake, not from lack of availability of food. The inadequate dietary intake of hospitalized patients stems from the anorexia, malabsorption, and/or increased metabolic rate which accompany many diseases.[2] Because untreated malnutrition in hospitalized patients increases morbidity and mortality, early recognition of nutritional deficiencies and rapid therapeutic intervention are essential.

The Initial Assessment

The complexity of nutritional assessment results from the inability to characterize nutritional abnormalities by a single clinical or laboratory parameter. Although an extensive battery of tests will quantify nutritional deficits, expense precludes performing this barrage of tests on every hospitalized patient. Therefore, clinical judgment must guide the physician who suspects nutritional abnormalities. The decision-making process is outlined in Figure 1.

Screening Tests to Identify Patients With Possible Malnutrition

1) Recent involuntary weight loss exceeding 5% over 1 month or 10% over 6 months.

2) History of recent physiologic stress within the last three months, such as major surgery or illness lasting 3 weeks.

3) Total lymphocyte count (% of lymphocytes × white blood count) less than 1500 cells/mm.^{3}

4) Serum albumin less than 3.5 grams/dl.

Patients with positive replies to any of the above screening parameters are suspected to have malnutrition and are candidates for complete nutritional assessment.

The Complete Assessment

The purpose of the complete assessment (Table 1) is two-fold:

1) To reveal aspects of protein-calorie malnutrition which may have been overlooked at the initial screening.

2) To quantitate nutritional abnormalities as a baseline for determining the efficacy of therapy.

Ideal Body Weight

After the height, weight, and sex of the patient have been recorded, the ideal body weight is determined from a nomogram (Table 2).

The percentage which actual weight constitutes of ideal body weight is calculated, as is the percentage

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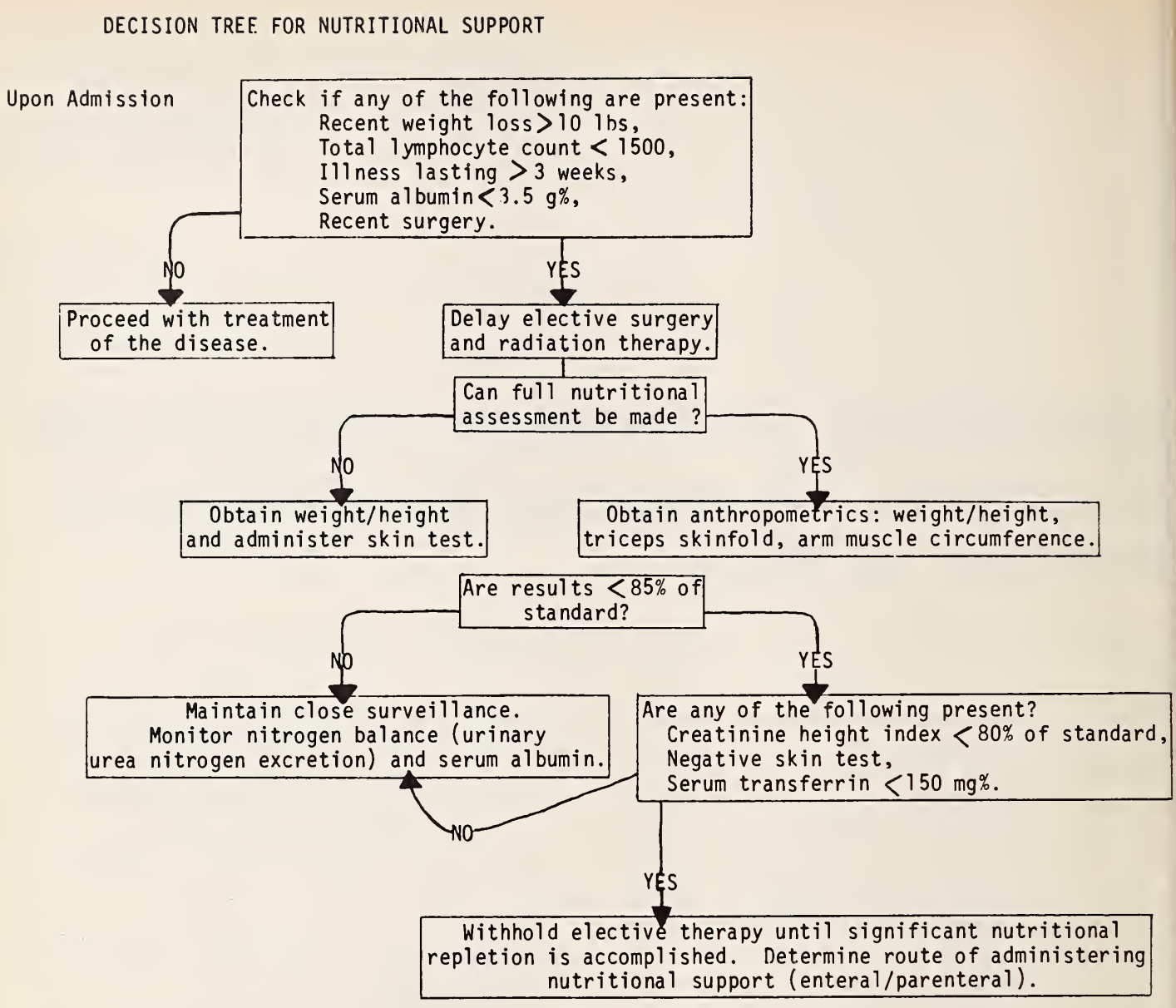


Figure 1

of weight change. Weight is an important parameter, but because its capacity to assess nutritional status is limited by obesity and edema, additional parameters must be measured.

Anthropometry

Anthropometric measurements estimate fat and skeletal muscle stores, which provide energy during periods of acute stress. The thickness of the triceps skinfold is a guide to adipose reserves, standard values of which are given in Table 3. Severe loss of adipose stores is indicated by triceps skinfold thickness less than 35% of the standard.

Available protein stores are estimated by measuring the arm muscle circumference (AMC). The AMC is measured at the same site as the triceps skinfold, halfway between the acromion process and olecranon of the non-dominant arm. Two assumptions are necessary to calculate the arm muscle circumference: 1) That a cross-section of the mid-arm musculature is circular, although in reality it is elliptical,[3] and 2) that the size of the humerus is consistent, when in fact variation does occur. Nevertheless, the arm muscle circumference is accessible, usually free of edema, and correlates with muscle wastage. Significant loss of skeletal muscle stores is indicated by values 60-80% of standard and severe loss by values less than 60% of standard (Table 4).

Visceral Proteins

In some patients, malnutrition is manifested by poor wound healing and abnormal host defense before abnormalities appear in adipose stores or lean body mass. The two most commonly used measurements of visceral protein malnutrition are the serum albumin and transferrin (Table 5). Although albumin levels are readily measurable, the relatively long half-life of 16-18 days limits the ability of albumin determinations to monitor acute changes in the visceral protein compartment.[3] Also, levels of serum albumin rise if infusions of colloid are given to maintain intravascular volume. Thus, it may be

TABLE 1 — Nutritional/Metabolic Variables Measured in a Complete Nutritional Assessment

Anthropometric Measurements		
*1	Height in cm	Ht:_____
*2	Weight in kg	Wt:_____
*3	Usual Weight in kg	Us Wt:_____
4	Sex (male/female)	Sex:_____
5	Ideal Body Weight in kg	IBW:_____
6	Weight as percent of IBW	%IBW:_____
7	Weight as percent of Usual Weight	%Us Wt:_____
8	Triceps Skinfold in mm	TSF:_____
9	Arm Circumference in cm	AC:_____
10	Arm Muscle Circumference in cm (derived)	AMC:_____
11	Triceps Skinfold as percent of standard	%TSF:_____
12	Arm Muscle Circumference	%AMC:_____
Laboratory Determinations		
*†13	Serum Albumin in gm/dl	ALB:_____
†14	Total Iron-Binding Capacity in ug/100 ml	TIBC:_____
†15	Serum Transferrin in mg/100 ml Trans = (0.8 × TIBC) − 43	Trans:_____
*16	Lymphocytes as percent	%Lymph:_____
17	White Blood Cell Count in no./mm^3	WBC:_____
18	Total Lymphocyte Count (derived)	TLC:_____
†19	24-Hour Urine Urea Nitrogen in gm	UUN:_____
20	24-Hour Urinary Creatinine in mg	UCR:_____
†21	Creatinine Height Index as percent of standard	%CHI:_____
Diet and Nutrition Status		
22	Protein Intake in gm	Pro:_____
23	Caloric Intake in kcal	Cal:_____
24	Nitrogen Balance in gm (derived)	N_{bal}:_____
25	Obligatory Nitrogen Loss in gm	N_{obg}:_____
26	Net Protein Utilization (apparent) (derived)	NPU:_____
27	Basal Energy Expenditure in kcal/day (derived)	BEE:_____
28	Caloric Intake as percent of BEE (derived)	%BEE:_____
†29	Skin Test results in mm	St:_____

* Variables necessary for a routine screening.
† Variables necessary for a rapid and sensitive nutritional assessment.

difficult to correlate changes in nutritional status with fluctuations in serum albumin.

Transferrin, however, has a half-life of only 6 to 8 days. Moreover, its value is independent of albumin infusions.[4]

Delayed Hypersensitivity

Because the most common cause of death in malnourished patients is sepsis, the evaluation of immune competency plays an important role in nutritional assessment. Immune competency is reflected in the total lymphocyte count[5] and tested directly by the response to antigens, such as Candida, mumps, tetanus, and streptokinase-streptodornase (SK-SD). A response of at least 5 mm induration to two antigens 24 to 48 hours after intradermal injection is considered positive. Lack of induration may be seen in patients immediately after surgery and in patients on corticosteroids; these patients should be retested several weeks later.

TABLE 2* — Ideal Weight for Height Males and Females

Height (cm)	*Weight (kg)*	*Height (cm)*	*Weight (kg)*	*Height (cm)*	*Weight (kg)*
			Males		
145	51.9	159	59.9	173	68.7
146	52.4	160	60.5	174	69.4
147	52.9	161	61.1	175	70.1
148	53.5	162	61.7	176	70.8
149	54.0	163	62.3	177	71.6
150	54.5	164	62.9	178	72.4
151	55.0	165	63.5	179	73.3
152	55.6	166	64.0	180	74.2
153	56.1	167	64.6	181	75.0
154	56.6	168	65.2	182	75.8
155	57.2	169	65.9	183	76.5
156	57.9	170	66.6	184	77.3
157	58.6	171	67.3	185	78.1
158	59.3	172	68.0	186	78.9
			Females		
140	44.9	150	50.4	160	56.2
141	45.4	151	51.0	161	56.9
142	45.9	152	51.5	162	57.6
143	46.4	153	52.0	163	58.3
144	47.0	154	52.5	164	58.9
145	47.5	155	53.1	165	59.5
146	48.0	156	53.7	166	60.1
147	48.6	157	54.3	167	60.7
148	49.2	158	54.9	168	61.4
149	49.8	159	55.5	169	62.1

* This table corrects the 1959 Metropolitan Standards to nude weight without shoe heels. Adapted from Jelliffe, D.B., The Assessment of the Nutritional Status of the Community, W.H.O., Geneva, 1966.

TABLE 3 — Adult Standards for Triceps Skinfold Measurements

	Standard (mm)	*35% of Standard (mm)*
Male	12.5	4.4
Female	16.5	5.8

TABLE 4 — Adult Standards for Arm Muscle Circumference (AMC*)

	Standard	*80% of Standard (mm)*	*60% of Standard (mm)*
Male	25.3	20.2	15.2
Female	23.2	18.6	13.9

* AMC = AC − 0.34 TSF; where AC = arm circumference, and TSF = triceps skinfold.

TABLE 5 — Visceral Protein Malnutrition

Assessment of Malnutrition	*Serum Albumin (g/100 ml)*	*Serum Transferrin (mg/100 ml)*
Mild	3.0-3.5	150-175
Moderate	2.1-2.9	100-149
Severe	2.1	100

Sepsis in malnourished patients, for example, an abdominal abscess, culture-proven pneumonia, or positive blood cultures not due to contamination from the skin, usually results from different organisms than the ones seen in the DiGeorge Syndrome and other disorders of cell-mediated immunity. Nevertheless, a strong relationship exists between anergy and sepsis. In a study of 229 hospitalized patients, the 87 anergic patients had a sepsis rate of 44% and a mortality of 39%, in contrast to a sepsis rate of 29% ($p<0.05$) and a mortality of 16% ($p<0.01$) in the 142 patients with intact delayed hypersensitivity.[2]

Creatinine-Height Index (CHI)

The amount of urinary creatinine excreted over 24 hours reflects what transpires within the metabolically active tissues of the body. Measurements of accurately collected 24-hour urine creatinine are more closely related to basal oxygen consumption and lean body mass than weight or anthropometric measurements.[3] The creatinine-height index has been determined from the 24-hour urinary creatinine excretion of healthy individuals of given heights (Table 6). The advantage of an index related to height is that height remains unaltered by malnutrition and thus offers a constant reference point from which to assess changes in metabolically active tissue:

$$\text{CHI} = \frac{\text{Measured urinary creatinine}}{\text{Ideal urinary creatinine}} \times 100$$

Nitrogen Balance

The 24-hour urinary urea nitrogen is determined at the same time as the urinary creatinine. It is used to measure nitrogen balance, which tells whether the nutritional support has been sufficient to prevent catabolism. Losses of urea nitrogen from feces, skin, and the respiratory tract average 4 grams/day regardless of nutritional status. Dividing the protein intake by 6.25 yields the nitrogen intake:

$$\text{Nitrogen balance} = \text{nitrogen intake} - \text{nitrogen excretion}$$

$$\text{Nitrogen balance} = \frac{\text{protein intake (grams)}}{6.25} - (\text{urine urea nitrogen} + 4)$$

Nitrogen balance studies indirectly measure the level of ongoing stress, because they do not account for the effect of different protein intakes. For example, a fasting patient consuming negligible amounts of nitrogen is less physiologically stressed than a burned patient consuming 20 grams of nitrogen even if both have the same nitrogen balance. The stress index developed by Bistrian increases the sensitivity of nutritional assessment by weighing the effects of protein intake upon metabolism. In the equation listed below, one half of the dietary intake represents the net protein utilization of a well-nourished individual with an adequate protein and energy intake; thus, 50% is an estimate of net protein utilization in unstressed hospitalized patients, from which the predicted urine urea nitrogen values are derived. The number "3" represents the measured obligatory loss of urea nitrogen from the urine.[6]

TABLE 6 — Nutritional Assessment of the Hospitalized Patient — Ideal Urinary Creatinine Values

*Men**		*Women†*	
Height (cm)	*Ideal Creatinine (mg)*	*Height (cm)*	*Ideal Creatinine (mg)*
157.5	1,288	147.3	830
160.0	1,325	149.9	851
162.6	1,359	152.4	875
165.1	1,386	154.9	900
167.6	1,426	157.5	925
170.2	1,467	160.0	949
172.7	1,513	162.6	977
175.3	1,555	165.1	1,006
177.8	1,596	167.6	1,044
180.3	1,642	170.2	1,076
182.9	1,691	172.7	1,109
185.4	1,739	175.3	1,141
188.0	1,785	177.8	1,174
190.5	1,831	180.3	1,206
193.0	1,891	182.9	1,240

* Creatinine coefficient (men) = 23 mg/kg of *ideal* body weight.
† Creatinine coefficient (women) = 18 mg/kg of *ideal* body weight.

Stress index = 24 hour urinary urea nitrogen − (½ dietary nitrogen intake + 3)

−5 − 0 = no significant stress
1 − 5 = moderate stress
>5 = severe stress

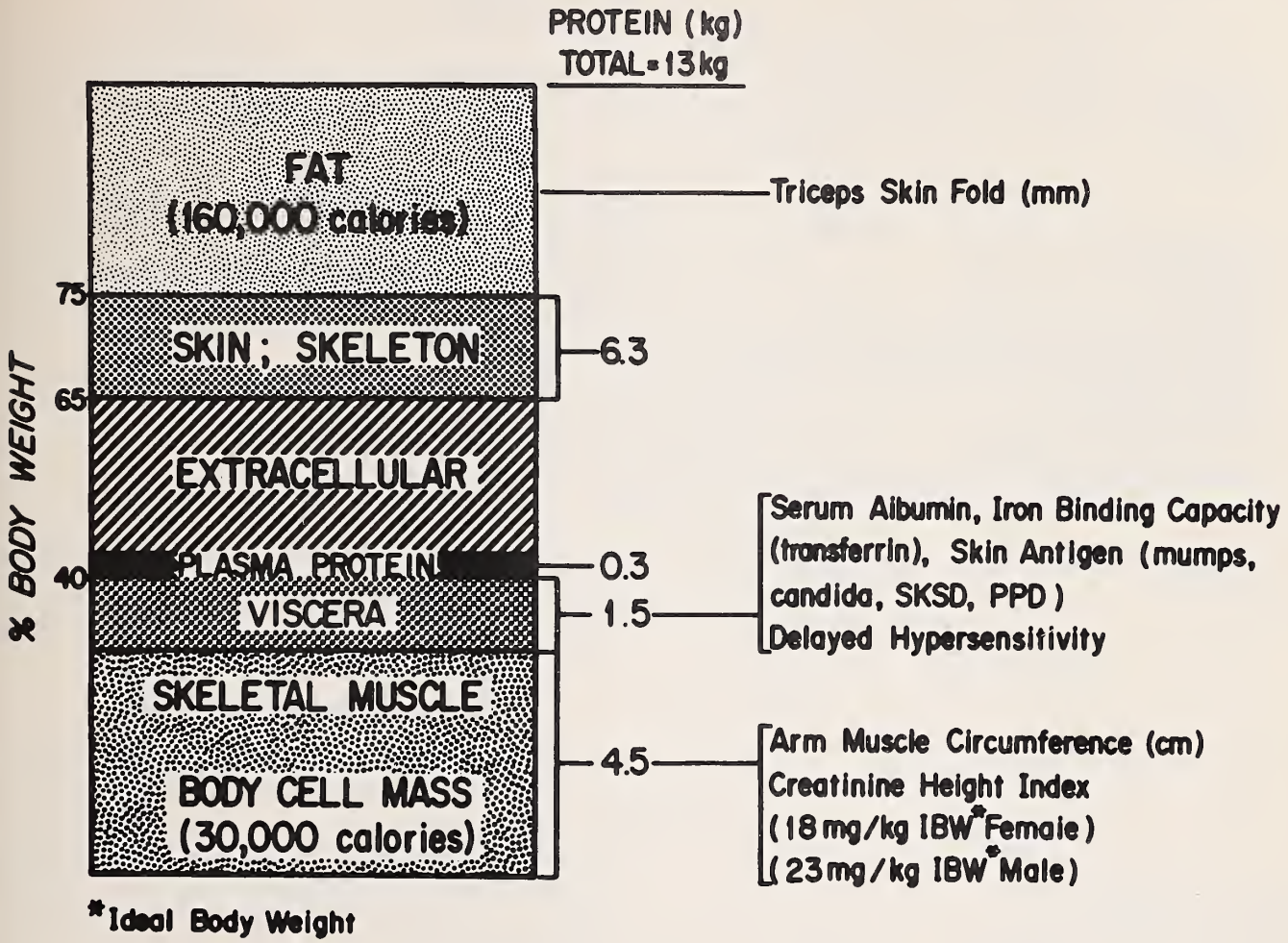
In summary, Figure 2 identifies nutritional assessment techniques with their corresponding body compartments. Note the large number of calories which can be obtained by metabolizing fat stores.

Prognostic Nutritional Index

The purpose of nutritional assessment is to identify malnourished patients as soon as possible after they enter the hospital. The degree of protein-calorie malnutrition predicts survival more accurately than even the primary disease classification.[2] This observation has been confirmed by Mullen et al.[7] who developed the prognostic nutritional index (PNI), a weighted index of nutritional assessment parameters based on linear discriminant function analysis and stepwise regression. High-risk patients suffered a six-fold increase in complications, a ten-fold increase in major sepsis, and a twelve-fold increase in mortality relative to low-risk patients.

PNI = 158% − 16.6 (Serum albumin) − 0.78 (triceps skinfold − 0.2 (transferrin) − 5.8 (delayed hypersensitivity)*

* Delayed hypersensitivity scored:
0 if no induration on any site 24-48 hours after injection
1 if 1-5 mm induration on any site 24-48 hours after injection
2 if >5mm induration on any site 24-48 hours after injection



The major parameters for the assessment of nutritional status with corresponding components of body composition.

Figure 2

PNI Score	*Risk Category*
50%	High Risk
40-49%	Intermediate risk
40%	Low risk

Classification of Malnutrition

After the nutritional assessment has been completed, the pattern of malnutrition may be categorized as marasmus or kwashiorkor.

Marasmus, or skeletal protein malnutrition, is characterized by depressed anthropometric measurements, a decreased creatinine-height index, and relative sparing of visceral protein. Anergy usually does not occur except in severe instances. Marasmus results from inadequate protein and energy intake. Commonly observed in geriatric and convalescent populations, marasmus tends to be well-tolerated only in the absence of stress.

Kwashiorkor, or visceral protein malnutrition, is characterized by decreased serum albumin and transferrin, impaired cell-mediated immunity, and normal anthropometric measurements. Resulting from semi-starvation and the stress of illness, kwashiorkor is poorly tolerated in hospitalized patients and requires urgent correction.[5] (Table 7).

Overview of Patient Eligibility

Although the number of candidates for nutritional assessment seems large, the process of selection is simplified by considering three guidelines for nutritional support:

1) treatment of protein-calorie malnutrition;
2) reversal of severe catabolism; and
3) support of carefully selected patients with chronic disabling diseases.

Protein Calorie Malnutrition

Decisions regarding the treatment of protein-calorie malnutrition are made frequently prior to elective surgery in high-risk patients. If the patient is deemed malnourished by the nutritional assessment techniques described above, elective surgery should

TABLE 7 — Classification of Malnutrition

	% Ideal Weight	*Creatinine Height Index %*	*Skin Test Reactivity (mm of induration)*
A. Marasmus			
Moderate	60-80	60-80	≥5*
Severe	<60	<60	<5*

	Serum Albumin	Serum Transferrin	Total Lymphocyte Count	Skin Test (mm)
B. Kwashiorkor				
Moderate	2.1-3.0	100-150	800-1,200	<5*
Severe	<2.1	<100	<800	<5*

* Treatment of malnutrition requires characterization into two general categories that reflect their:
1. Different consequences in terms of morbidity and mortality.
2. Different treatment modalities.
3. Different pathogenesis.

These diseases should be coded so that they will appear on hospital discharge summaries and in health planning statistics.
ICDA — International Classification
Protein malnutrition-Kwashiorkor-like — Nutritional marasmus — Other nutritional disorders — unspecified.

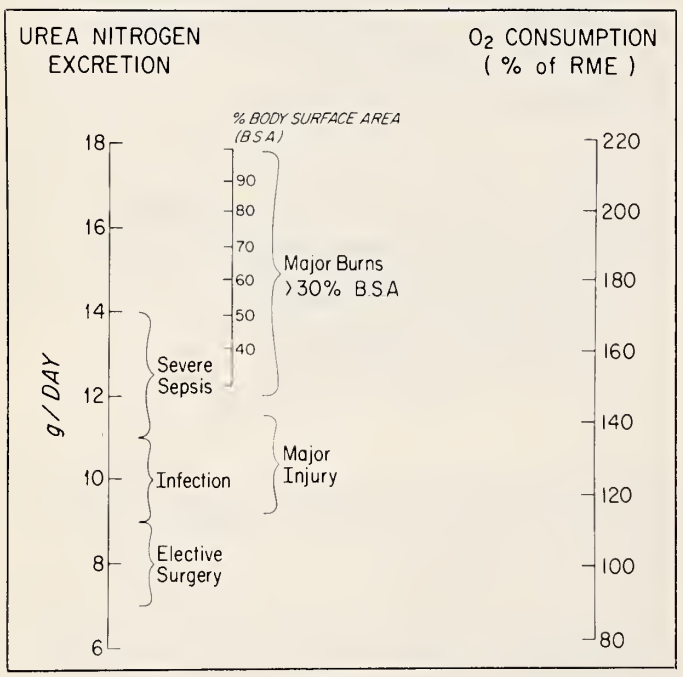


Figure 3

be postponed until nutritional health has been restored. Patients who overcame their anergy and had a rise in serum transferrin of 29 ± 6 mg/dl had one quarter the mortality of patients in whom these parameters declined or remained unchanged.[2]

Role of Catabolism

As can be seen in Figure 3, the basal metabolic rate rises to high levels in patients who have sustained multiple trauma or burns of at least 30% body surface area. The stress of sepsis is more insidious but often as catabolic and potentially lethal as that of trauma and burns. Defined as a positive blood culture, intra-abdominal abscess, or culture-proven pneumonia, sepsis was listed as the major cause of death in 56 patients out of a total of 229 general surgical consults to the nutrition support service.[2] Therefore, nutritional assessment should play as important a role in the evaluation of critically ill patients with systemic sepsis as cultures and antibiotics.

Chronic Disabling Diseases

Chronic diseases can produce malnutrition via two different mechanisms. The first mechanism involves diseases which interfere with absorption from the gastrointestinal tract. Examples include fistulae, chronic pancreatitis, inflammatory bowel disease, radiation enteritis, bowel obstruction, and short bowel syndrome.

In addition, chronic diseases can produce malnutrition as a side effect of the disease process or as a consequence of therapy. Some patients with chronic renal, hepatic, or cardiac failure suffer anorexia, and the dietary restrictions imposed upon them by their treatment may result in unpalatable meals. Thus, a cycle begins of physical deterioration, dietary restriction, anorexia, and further physical deterioration. When combined with the stress of surgery, sepsis, and intercurrent illness, this cycle may be lethal.[8] The purpose of this paper is not to assert that every patient with chronic cardiac, renal, and hepatic failure should undergo nutritional assessment, but to explain the rationale for this procedure in carefully selected patients.

Even more controversial is the role of nutritional assessment and intervention of anorectic patients receiving therapy for cancer. The suitability of cancer patients for nutritional support is decided by individualized case reviews.

Nutritional Intervention

Nutritional assessment and intervention are not controversial at the extremes of the spectrum. The healthy patient whose illness and therapy will not

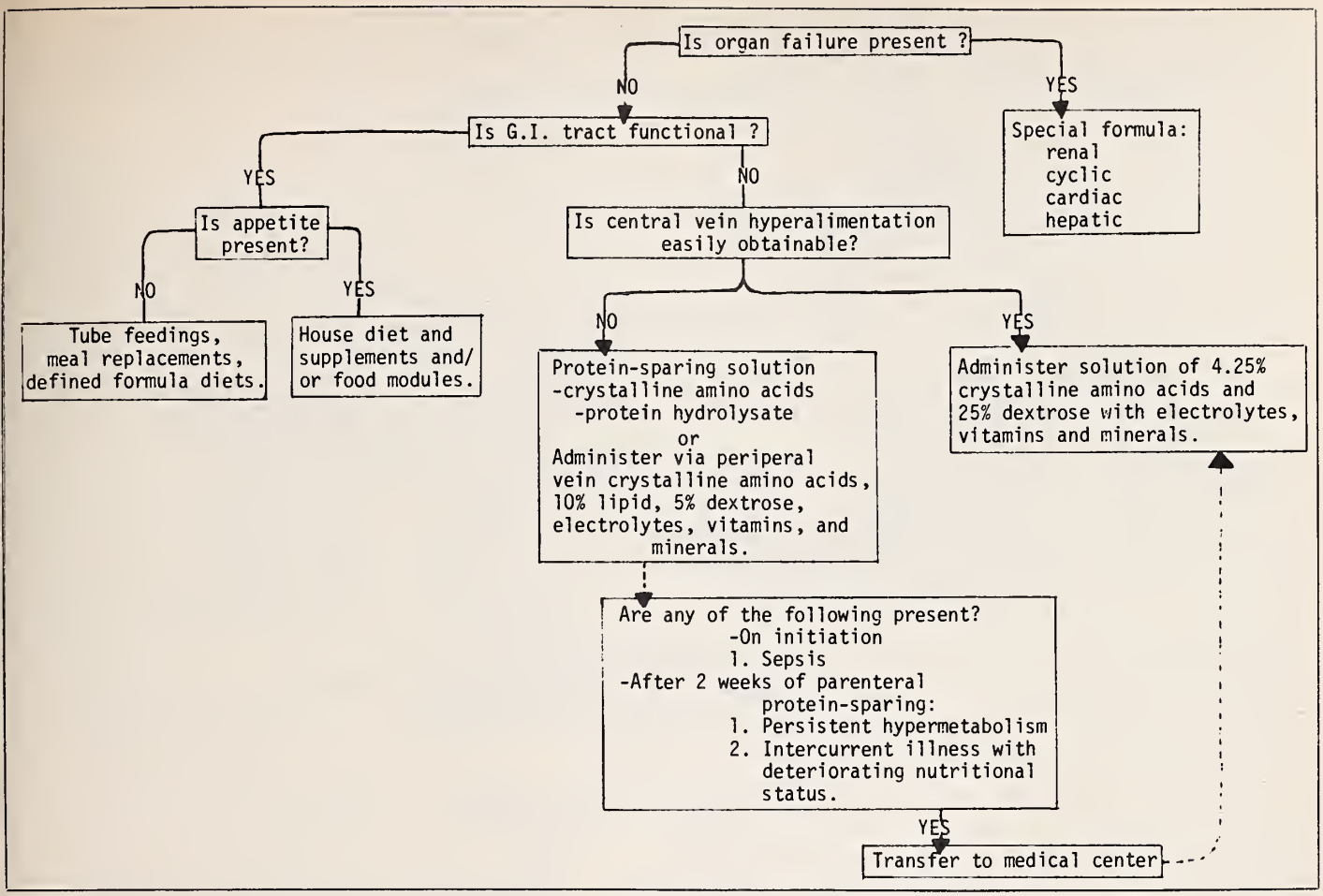


Figure 4

TABLE 8 — Time Allowed for Adequate Voluntary Oral Intake Before Instituting Nutritional Support

State of Nutrition	*Unstressed*	*Stressed*
Well nourished	**5-7 days**	**3-5 days**
Malnourished	**3-5 days**	**1-3 days**

permit oral intake for several days is not a candidate for nutritional intervention. Likewise, most physicians would not question the need for nutritional support in a viable, debilitated patient with a potentially curable disease. Nutritional assessment may clarify the type of malnutrition, but decisions regarding nutritional intervention are based upon a *clinical* assessment of the patient, the degree and duration of stress, and the extent of protein-calorie malnutrition. As outlined by Mullen,[7] decisions regarding nutritional intervention are based upon the:

1) baseline nutritional status of the patient;

2) nutritional consequences of the patient's illness and therapy;

3) the patient's nutrient requirements, determined from the nutritional status, illness, and therapy; and

4) anticipated ability of the patient to meet the nutritional requirements voluntarily via the oral route (Table 8).

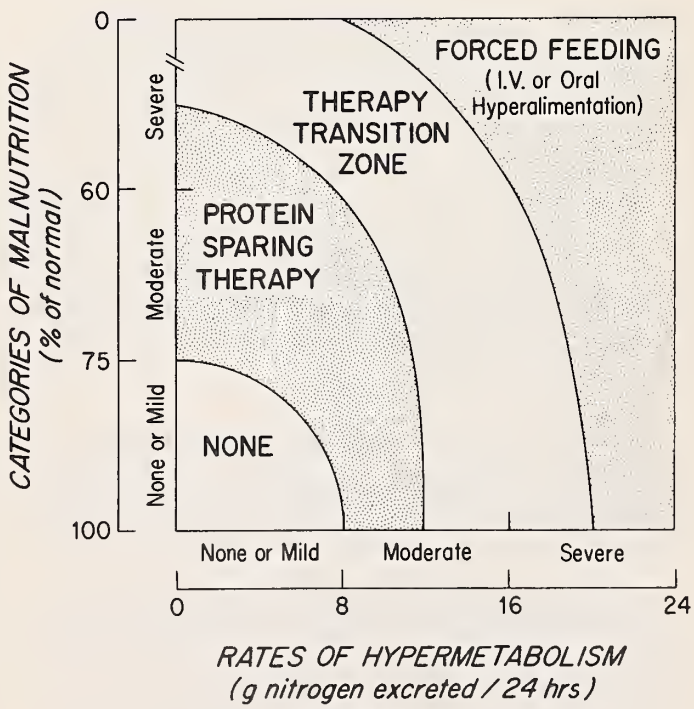


Figure 5

Route of Administration

Figure 4 displays the logic used in selecting a particular route of nutritional support. If the gastrointestinal tract is available, it is utilized via oral supplementation, nasogastric intubation, gastrostomy, or jejunostomy, depending on the patient's

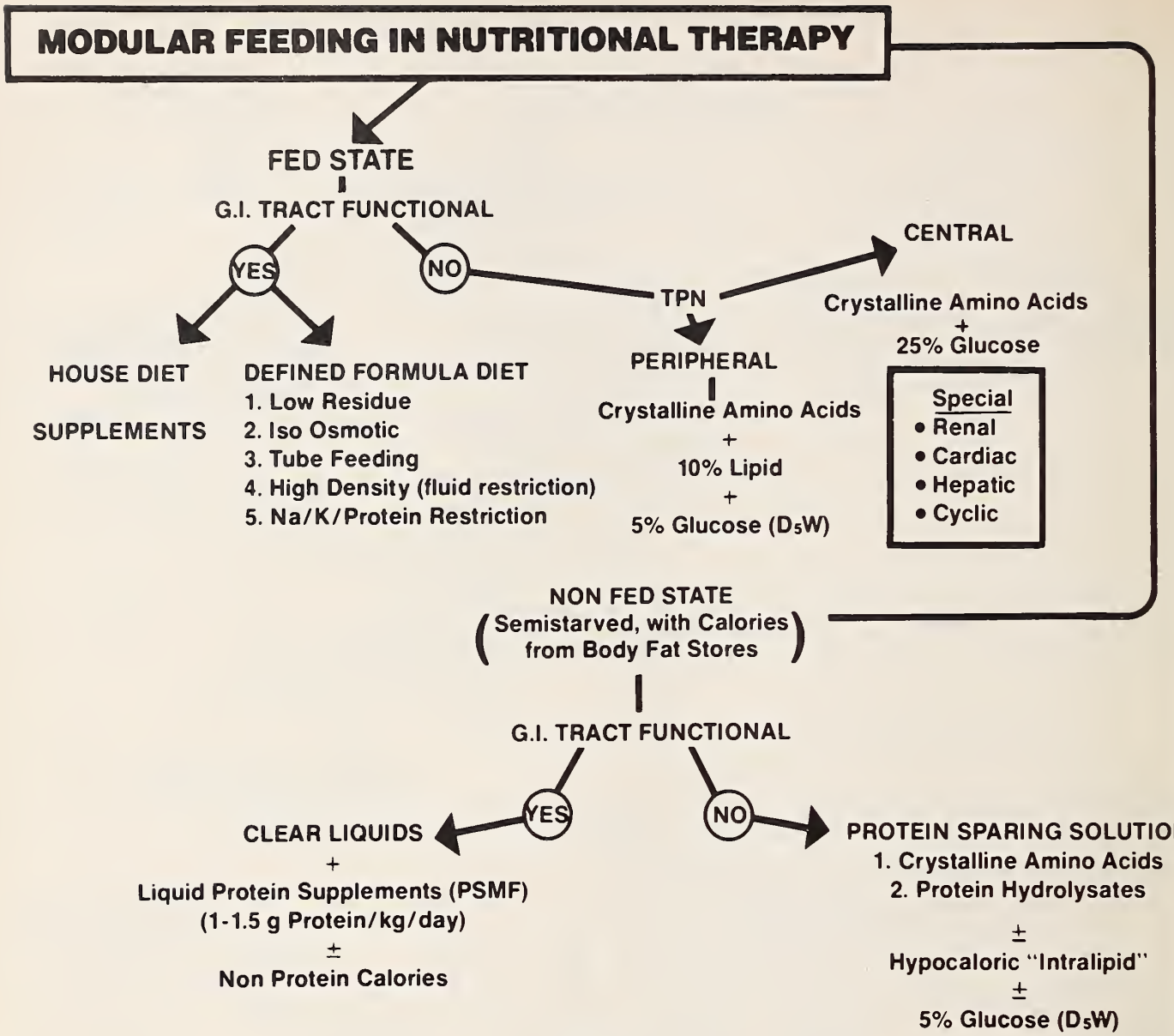


Figure 6

nutritional status, protein/calorie requirements, and tolerance of different types of nutritional support. Modules are available which increase the protein or calorie content of the feedings.

Indications for Protein Sparing Therapy

Within the limits of malnutrition and stress outlined in Figure 5, protein-sparing is used in patients in whom:

1) the gastrointestinal tract is unavailable;
2) interruption of oral intake is estimated to be no more than 2 weeks;
3) adequate fat stores are present; and
4) peripheral venous access is adequate.

Rationale for Protein Sparing

Restricting carbohydrate intake to less than 50 grams per day maintains low plasma levels of insulin. Usually within 48 hours after beginning protein-sparing therapy, hepatic glycogen stores are consumed, and fat is oxidized as the primary fuel source, preserving skeletal and visceral protein.[9] The presence of ketone bodies in the urine confirms that adipose tissue is being oxidized and indicates successful therapy.

The cessation of ketosis, when not the result of carbohydrate administration, often precedes a new stress, such as infection. During stress, release of catecholamines, corticosteroids, and glucagon can lead to insulin resistance and increased levels of circulating insulin. High levels of insulin interfere with fat mobilization and thus increase the oxidation of glucose and amino acids to meet energy needs. Thus, if hepatic glycogen stores have been exhausted, breakdown of endogenous proteins for energy occurs rapidly.

Parenteral Nutrition

As shown in Figure 6, nutrients are administered into a central vein when protein-sparing is inappropriate and protein-calorie requirements exceed anticipated oral intake. In both parenteral and enteral

TABLE 9 — Guidelines for Anabolism

	Protein 24 h	*Calories Kcal 24 h*	*Calories (related to basal energy expenditure)*
Route			
Enteral	**1.2-1.5 × ideal body weight**	**35 × IBW**	**1.5 × BEE**
Parenteral	**1.2-1.5 × ideal body weight**	**40 × IBW**	**1.75 × BEE**

TABLE 10 — Schedule of Continuing Nutritional Assessment for Patients Receiving Enteral and Parenteral Hyperalimentation

Parameter	*Frequency*
1. Weight	**1. Daily**
2. Calorie counts (where applicable)	**2. Daily**
3. Glucose and electrolytes	**3. At least daily initially until stable, then at least biweekly.**
4. BUN, creatinine, calcium, phosphate, alkaline phosphatase, SGOT, LDH, albumin	**4. 1-2 times per week.**
5. Total lymphocyte count, 24-hour urine for urea, nitrogen and creatinine, prothrombin and partial thromboplastin time.	**5. Weekly**
6. Delayed hypersensitivity testing Transferrin, anthropometric measurements.	**6. Every 3 weeks.**

nutrition, special formulae are available for patients with cardiac, renal, and hepatic failure. With patients in whom central venous access is technically impossible or contraindicated because of severe bleeding diatheses or previous subclavian thrombosis, peripheral venous alimentation is used with amino acids, lipid, and 5% dextrose.

The rate of administration of nutritional support is based upon the: 1) degree of malnutrition, 2) severity of stress as determined from urinary nitrogen assays, 3) difference between the voluntary oral intake and the daily caloric requirements for anabolism (Table 9) as calculated from the Harris Benedict Formula.

$$\text{Men: BEE} = 66.5 + 13.8\,W + 5.0\,H - 6.8\,A$$
$$\text{Women: BEE} = 55.1 + 9.1\,W + 1.8\,H - 4.7\,A$$

where: C = Kcal/day, W = usual weight (kg), H = height (cm) and A = age (years).

Although the estimated protein requirement for anabolism is 1.2-1.5 g/kg, less protein is administered to patients with hepatic and renal failure.[10] Fluid volume is also individualized, increased in some patients with dehydration or small bowel obstruction, and decreased in some patients with renal and cardiac failure. Maintenance of tight control over fluid volume requires communication and cooperation with the pharmacy and the patient's principal physicians.

Increased carbon dioxide production and fatty infiltration of the liver without increased energy production have been reported in patients receiving over 4 mg/kg/min of glucose (equivalent to 5.8 g/kg/d, or approximately 400 g/d in a 70 kg male).[11] These data contradict the myth that if some parenteral nutrition is good, more is better, and underscore the importance of using intravenous fat emulsions to aid in meeting caloric requirements where necessary to prevent infusion of excess carbohydrate.

Duration of Therapy

The initial assessment serves as a baseline from which the progress of therapy can be monitored. The frequency of follow-up testing is given in Table 10. The patient's weight is ordered to be performed at the same time every day because it tends to be incorporated into treatment regimens and be performed more regularly than when it is ordered for alternate days. Any accurately recorded weight gain exceeding 0.7 lbs per day is interpreted as volume overload, rather than anabolism, and the patient's regimen is altered by concentrating fluid volume or by administering a diuretic. Weekly measurement of urinary creatinine and urea nitrogen helps to confirm that the correct prescription is being administered as the level of stress changes.

Conclusion

Clinical judgment remains the key to deciding the extent of nutritional assessment and intervention. The diagnosis of malnutrition rests upon the entire assessment rather than upon the results of any single laboratory test. Ideally, nutritional assessment should be performed sufficiently early in the hospital course to ensure that intervention, where necessary, begins before sepsis and increased stress precipitate further decline in the patient's condition.

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The author describes a method of cerebral revascularization for patients manifesting cerebral ischemic symptomatology with an "inaccessible" vascular lesion.

Microsurgical Cerebral Revascularization: The Extracranial-Intracranial Bypass for Stroke Prevention

ALAN S. FLEISCHER, M.D., ***Atlanta****

STROKE IS A MAJOR health care problem, remaining the most costly single disease in the United States. Each year more than 450,000 persons suffer strokes; ⅓ of these patients die, ⅓ suffer disability, and ⅓ return to independent function.[1] Stroke remains the third leading cause of death after heart disease and cancer, and it is estimated that today there are over 2 million people in this country who are disabled secondary to stroke, with the majority of these in their most productive years. Contrary to popular opinion, this disease is not limited to the elderly. Approximately two-thirds occur in persons under the age of 65, and half of these occur in those under the age of 55.[2]

This paper will discuss ischemic stroke which comprises approximately 80% of the total, the remainder being hemorrhagic in etiology due to ruptured aneurysms, arteriovenous malformations, hypertension, etc.[2] Fortunately, a large percentage of ischemic strokes are preceded by so-called "warning signs." Therefore, this makes the most meaningful treatment for ischemic stroke prophylaxis. Five to 60% of patients with transient ischemic attacks (TIA) will have a completed stroke within one year and up to 75% within three years. The mortality rate in TIA patients with stroke is 5% in the first year and 21% within 4 years. The mortality rate in the prolonged reversible neurologic deficit (PRND) group of patients over a 4-year period ranges from 17% to 40%, while up to 55% deteriorate neurologically during the same period. Ischemic stroke itself, or completed stroke (CS), is perhaps the most dramatic of all warning signs, with 29 to 40% of patients with CS succumbing within 3 years from another stroke.[3]

Fortunately for those patients who heed the warning signs, early treatment of vascular problems can avoid the increased risk of stroke. The majority of these patients, approximately 65%, are found to have large vessel disease, half of which is due to carotid bifurcation narrowing and/or ulceration which is directly accessible for surgical correction.[3] The remainder of these patients subject to ischemic stroke, approximately 30 to 35%, have what are considered to be "inaccessible lesions."[4] Inaccessible cerebrovascular lesions include arterial stenosis or occlusion above an imaginary line joining the ramus of the mandible to the mastoid process. Inaccessible lesions beyond the reach of the neurosurgeon or the vascular surgeon in terms of direct repair therefore consist of internal carotid artery occlusion either extracranially or intracranially, intracranial internal carotid artery stenosis, middle cerebral artery stenosis, and middle cerebral artery occlusion (Table 1). Similar problems may occur with the vertebrobasilar circulation; however, this communication is limited to the cerebral circulation. The purpose of this paper is to describe a method of cerebral revascularization for patients manifesting

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TABLE 1 — Inaccessible Lesions

Internal carotid artery occlusion
A) Extracranial
B) Intracranial
Intracranial internal carotid artery stenosis
Middle cerebral artery stenosis
Middle cerebral artery occlusion

cerebral ischemic symptomatology with an inaccessible vascular lesion. This operative therapy, first performed in 1969, is designated an extracranial-intracranial bypass procedure (EC-IC bypass).

Stroke Terminology

Hemispheric transient ischemic attacks (TIAs) are episodes which produce a distinct neurologic deficit such as an hemiparesis, paresthesia, or dysphasia which clears in a matter of minutes or hours. The attack must be less than 24 hours in duration, and the patient must return to his pre-symptomatic state for the episode to be so defined. In monocular (Amaurosis fugax) episodes the patient has a transient loss of vision in one eye, often described as being like a "window blind" being pulled over the eye from above, which then gradually recedes. Vertebral transient ischemic attacks (TIAs) are episodes similar to those described above except that the symptoms include vertigo, diplopia, dysarthria, and bilateral or alternating paresis or paresthesia. The isolated occurrence or recurrence of vertigo, diplopia, amnesic episodes, drop attacks, or loss of consciousness is not accepted as evidence of vertebral-basilar disease.

A prolonged reversible neurologic deficit (PRND) is an episode which produces a neurologic deficit such as is described for TIAs which lasts longer than 24 hours but is followed by a return to the normal state.

A completed stroke (CS) is a definitive neurologic deficit which becomes static.

Patients and Methods

From November, 1974, to January, 1981, 175 EC-IC bypass procedures on 151 patients were performed at Emory University Hospital, Atlanta, Georgia, by the author. The average age of the patient undergoing surgery in this series was 59 years; 71% of the patients were men, 29% were women. The indications for EC-IC bypass procedure in this group included 101 patients with internal carotid artery occlusion either extra- or intracranially. Twenty-four of these patients with internal carotid artery occlusion had bilateral occlusion and underwent bilateral EC-IC bypass procedures. Twenty patients presented with stenosis of the intracranial internal carotid artery, 16 presented with middle cerebral artery stenosis, and eight presented with middle cerebral artery occlusion. An additional six patients underwent EC-IC bypass procedures prior to repair of a giant middle cerebral artery aneurysm or the treatment of Moya-Moya disease.

Treatment

To increase cerebral blood flow and to eliminate a source of emboli, accessible carotid bifurcation lesions have been approached operatively since the early 1950s. However, it was not until 1967 that a surgical procedure was developed for approaching "inaccessible" lesions. The foundation for such a procedure had been laid by Jacobson and Suarez[6] who, using the operating microscope and microinstruments available in the early 1960s, were able to anastomose one and two mm vessels which remained patent. In 1967, Yasargil, working in Donaghy's laboratory applied these techniques to the problem of cerebral revascularization by demonstrating the feasibility of anastomosing the superficial temporal artery (STA), an external carotid artery branch, to the cortical middle cerebral artery in the dog. One year later, Yasargil performed an EC-IC bypass procedure for a patient with hemispheric ischemia secondary to an occluded internal carotid artery.[5] In the past decade, over 2,000 such procedures have been performed for patients with these previously inaccessible vascular problems. Patients presenting with symptoms and signs of cerebral ischemia are evaluated with cerebral angiography. The finding of any of the previously mentioned inaccessible lesions makes the patient a candidate for the EC-IC bypass procedure.

Although the occipital artery may be used for the EC-IC bypass procedure,[7] the STA is by far the most common extracranial vessel used for this procedure. The technique used at Emory from 1974 to 1981 is basically the same as that described by Yasargil, with some modification. By referring to the angiogram and palpating the scalp, an STA branch is identified, preferably the posterior branch, and microsurgically dissected from its vascular bed from the underside of a scalp flap created by making a linear incision ending in a hockey stick shape (Figures 1 and 2). This is designed to include the area approximately 6 cm above the external auditory canal where the terminal branches of the middle cerebral artery that come to the cortical surface are mostly likely to be larger than 1 mm in diameter. A craniectomy approximately 2 cm in diameter is created to expose the area of the angular gyrus (Figure 1), the dura mater is opened in a cruciate fashion (Figure 3), and a 10 mm segment of an appropriate recipient cortical vessel is freed from the arachnoid (Figure 4). This work is performed meticulously under magnification of 10 to 25×, with bipolar

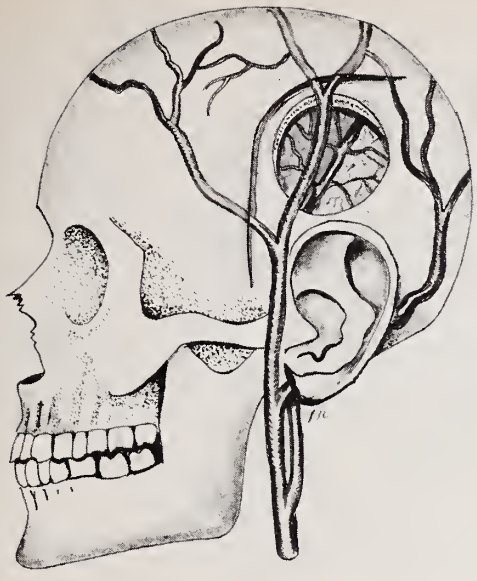


Figure 1 — The anatomy involved in the STAMCA anastomosis. The hockey stick shaped incision is outlined on the scalp. Shown also are the posterior branch of the STA, the craniectomy site, and the recipient cortical middle cerebral artery.

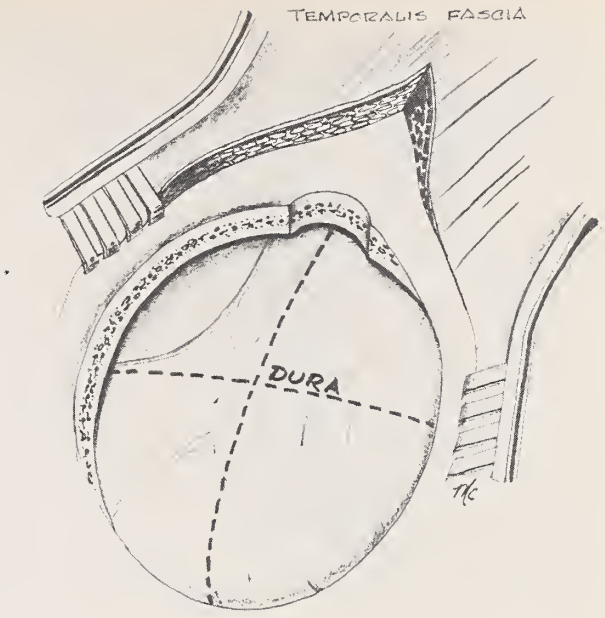


Figure 3 — Following division of the temporalis muscle, a craniectomy as depicted is performed and the dura opened in cruciate manner.

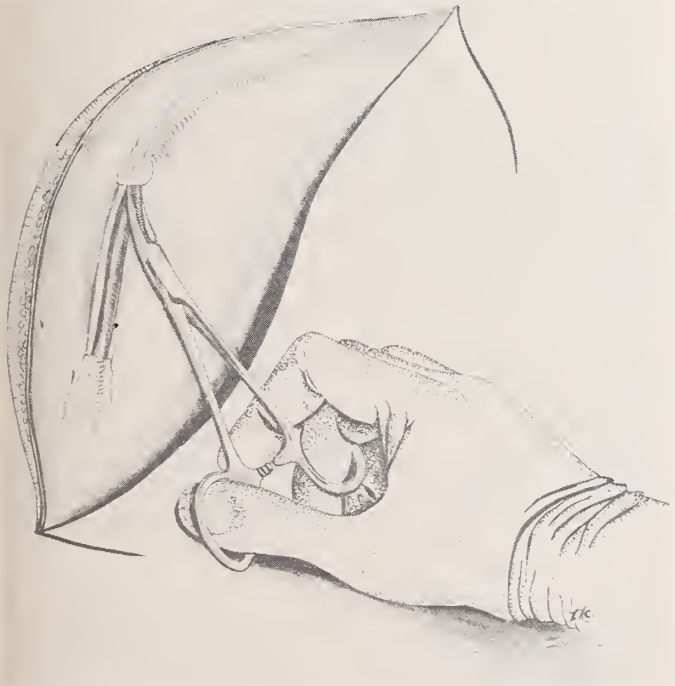


Figure 2 — Microscopic dissection of the posterior branch of the superficial temporal artery from the undersurface of the scalp flap.

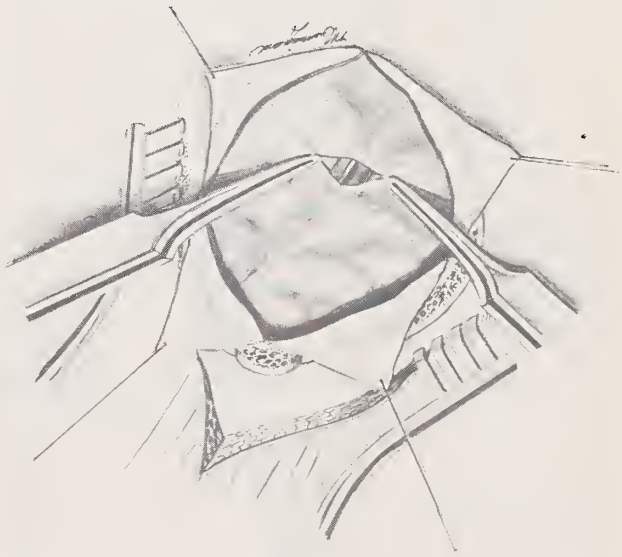


Figure 4 — Microsurgical dissection of arachnoid from the cortical middle cerebral artery branch which will be the recipient vessel of the anastomosis.

coagulation and microinstruments. The distal centimeter of the donor vessel is freed of adventitia (Figure 5), and its end is cut obliquely and fish mouthed (Figure 6). The cortical vessel is then isolated and a small square of silastic material placed beneath it to protect the underlying brain. Temporary clips are applied to the proximal STA and to the recipient cortical middle cerebral artery branch. It is important that the clips have low closing pressure so as to reduce the damage to the intima of these vessels. An arteriotomy is then made in the recipient vessel approximately two to three times the diameter of the donor vessel (Figure 7). The anastomosis is performed with approximately 16 to 18 interrupted 10-0 nylon sutures (Figure 8 and 9). Once flow is established and hemostasis assured, the craniectomy site is covered with gelfoam and the temporalis muscle closed with care so as not to occlude the donor vessel (Figure 10). The scalp is then closed in the usual fashion. The completed STA-MCA anastomosis is depicted in Figure 11 and 12.

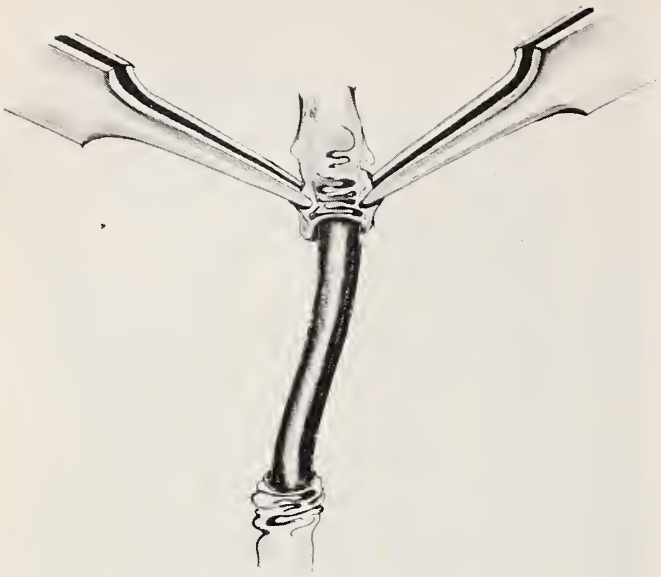


Figure 5 — Illustration of technique for removing adventitia tissue on the distal centimeter of the donor vessel.

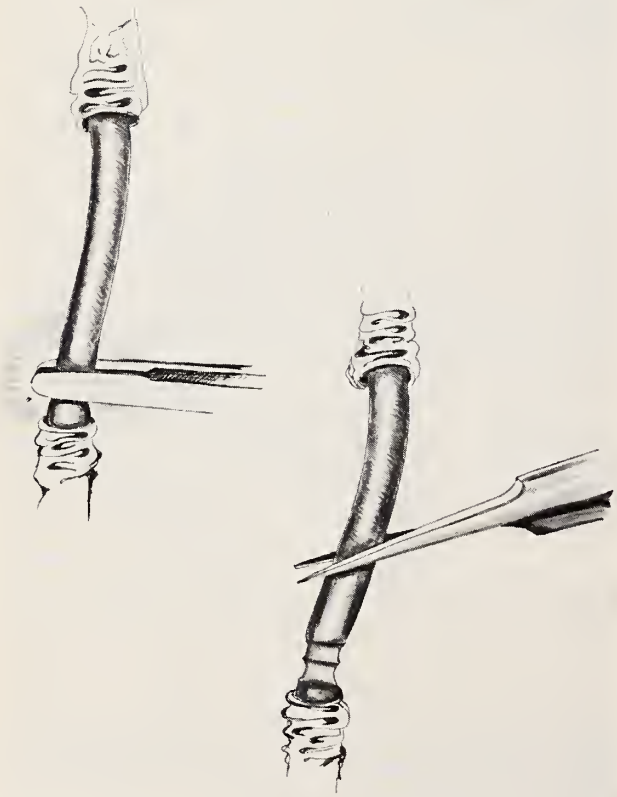


Figure 6 — After bipolaring the distal end of the superficial temporal artery (donor vessel), a proximal temporary clip is applied and the vessel divided obliquely.

A number of variations of this procedure have evolved in order to meet different anatomic situations. When the STA is too small (less than 1 mm diameter), the occipital artery may be used as the donor vessel. The occipital artery has also been used

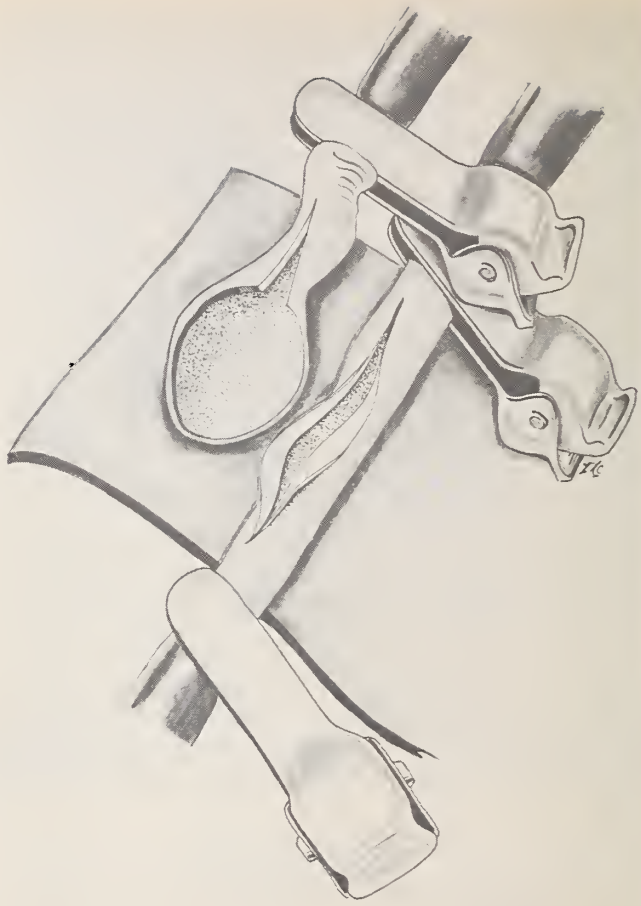


Figure 7 — At approximately 25 power magnification, this illustration depicts temporary clips in place on the donor vessel which has been divided obliquely and fish mouthed as well as on the recipient vessel on which an arteriotomy is performed. Note the silastic square protecting the brain surface beneath the anastomosis.



Figure 8 — High-power magnification of the placement of the polar sutures of 10-0 nylon in the initial phase of performing the anastomosis.

to deliver flow directly to the vertebrobasilar circulation via anastomosis with the posterior inferior cerebellar artery.[8] When no satisfactory extracranial vessel has been available, veins, segments of radial artery, and most recently synthetic expanded polytetrafluroethylene (GORE-TEX*) have been used.[9, 10]

* GORE-TEX, W. L. Gore and Associate, Flagstaff, AZ.

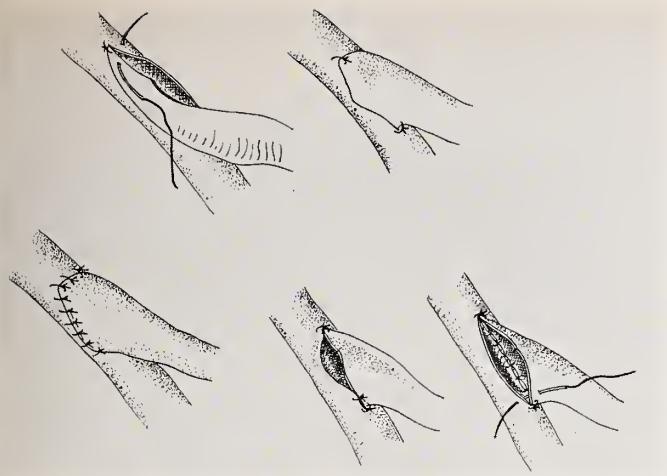


Figure 9 — Placement of the remainder of the sutures and the completion of the microvascular anastomosis.

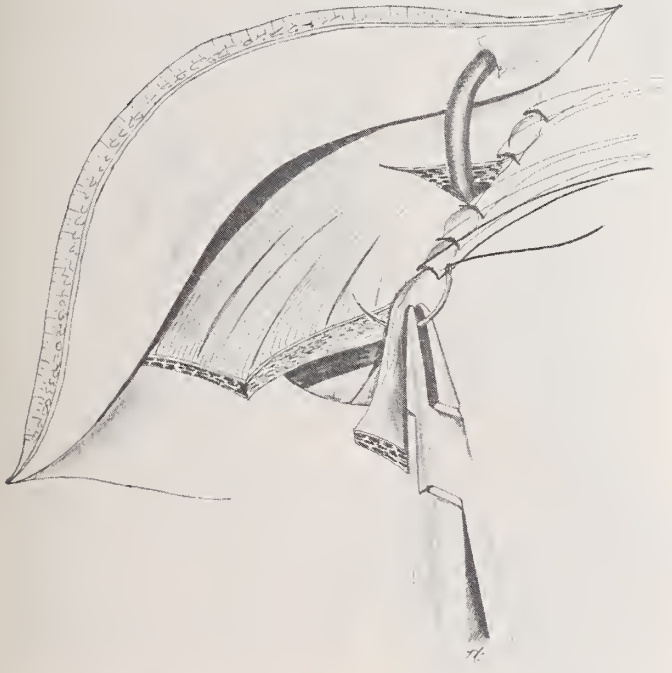


Figure 10 — The technique used to close a temporalis muscle in which an incision is made so as to avoid compression of the superficial temporal artery.

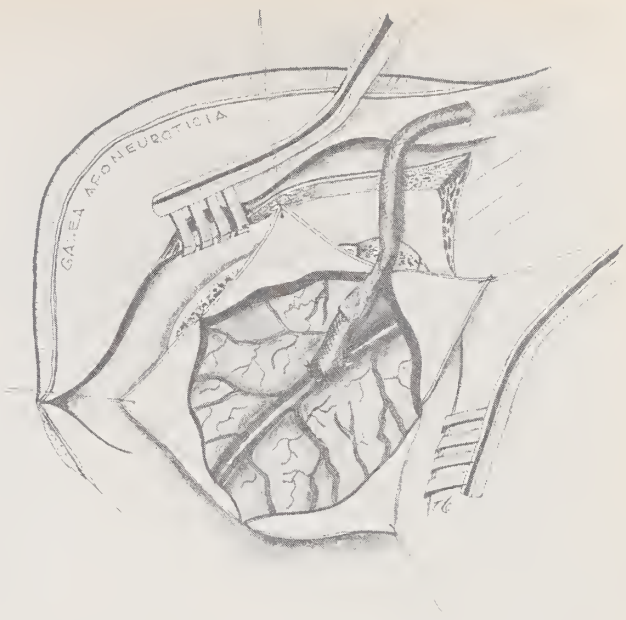


Figure 11 — Low-power magnification (approximately 10×) of the completed STAMCA anastomosis.

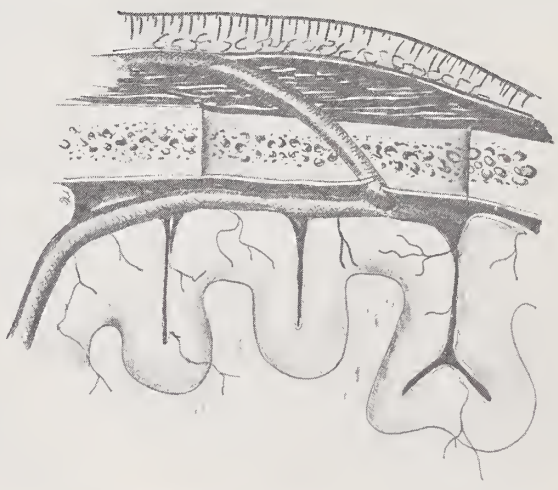


Figure 12 — Side view of the completed anastomosis.

Because cross clamping of the cortical vessel does cause an area of decreased cerebral blood flow, the duration of clamping should be minimal. Chater and Popp[11] have associated occluding the vessel for longer than 30 minutes with an increased incidence of minor neurologic defects which, fortunately, have usually cleared spontaneously. It is apparent that the surgical team involved in this procedure must be highly trained in order to keep the clamping time to a minimum and the chance of graft patency to the maximum.

Results

The recent review by Sampson and Boone[12] of the major series of cerebrovascular surgery results to date is encouraging. It demonstrates a marked lessening in the recurrence of TIAs following EC-IC bypass operations (85% to 95% of patients were free of TIAs, and in 5% to 8% the attacks occurred with markedly reduced frequency). Most important, the incidence of stroke has also been markedly reduced in these patients: only 3% to 4% of patients undergoing this procedure suffered strokes in the months following this procedure. In addition, the incidence of strokes in the group of patients with minor strokes and documented decreased cerebral perfusion has been markedly reduced. In this group, as many as 67% of unoperated patients have had a second stroke within 24 months of a first, minor stroke. When such patients received a bypass procedure, the stroke rate dropped to less than 2%. It is still questionable whether this procedure can improve the quality of function after even a minor stroke, however. The



Figure 13 — (A) Preoperative left carotid arteriogram demonstrating occlusion of the internal carotid artery at the bifurcation of the common carotid artery (curved dark arrow). This also demonstrates the STA (open arrows). (B) Postoperative (STAMCA anastomosis) angiogram depicting the STA (open arrows) filling the MCA (closed arrows) in one of the author's earliest cases.

results in the Emory series of 175 consecutive EC-IC bypass procedures are as follows. Two deaths occurred, one secondary to a hypertensive intracerebral hemorrhage occurring intraoperatively or immediately postoperatively and the second to a major hemispheric infarction. The morbidity includes one acute subdural hematoma and one subacute subdural hematoma, both of which were evacuated with no sequelae. There were two superficial infections which were successfully treated. Eighteen patients experienced transient minimal neurologic worsening; however, all returned to their preoperative state or improved. Angiographic patency rate is 95% (Figure 13), and one angiographically demonstrated pseudoaneurysm[13] spontaneously regressed over a period of 1 year to a normal-appearing anastomosis. The overall incidence of infarction in patients followed from 1974 through 1981 was 6%, which is considerably less than expected without the EC-IC bypass procedure.

Conclusion

Although the initial results of EC-IC bypass procedures are very encouraging, they are retrospective in nature. In order to establish a scientific value for this procedure, an international collaborative study has been initiated under the direction of Henry J. Barnett, M.D., at the University of Western Ontario (under the support of the United States National Institute of Neurological and Communicative Disorders and Stroke).[14] The specific objective of this study is to conclude whether "extracranial-intracranial bypass grafting will reduce by 50% or more the incidence of first or recurrent complicated strokes in patients with certain forms of cerebrovascular disease." The study is randomized with a strict protocol which includes obligatory follow-up of all patients for 5 years. Thus far, over 1,000 patients have been entered in the study in which Emory is participating.

Meanwhile, it appears from preliminary studies of others[15, 16] and the Emory experience that surgical intervention by well-trained teams of microvascular surgeons can benefit many of those patients who have transient focal ischemia or who have suffered a mild CS from lesions in previously "inaccessible" locations.

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Compared to amoxicillin

Faster peak. Fewer problems.

. . . in infants and children

Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).[1]

Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.[2]

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.[2]

CYCLAPEN®-W

(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.



*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.
†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.
2. Multicenter trials. Data to be published.

See important information on page after next.

Compared to ampicillin

Faster peak. Fewer problems.

. . . in adults and children



Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.[3]

Cyclapen®-W is just as effective in otitis media, bronchitis, pneumonia, urinary tract infections and infections of skin and skin structures†.[3]

Cyclapen®-W produces a significantly lower incidence of diarrhea and skin rash.[3]

CYCLAPEN®-W

(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.
†Due to susceptible organisms.
3. Data on file. Wyeth Laboratories.
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See important information on adjoining page.

Wyeth Laboratories
Philadelphia, Pa 19101

Cyclapen®-W (cyclacillin)

Indicatians
Cyclacillin has less in vitra activity than ather drugs in the ampicillin class and its use should be canfined ta these indicatians: Treatment af the following infectians:

RESPIRATORY TRACT
Tonsillitis and phoryngitis caused by Group A beta-hemolytic streptacacci
Bronchitis and pneumonia caused by *S. pneumanioe* (formerly *D. pneumaniae*)
Otitis media caused by *S. pneumaniae* (farmerly *D. pneumonioe*) and *H. influenzae*
Acute exacerbation af chronic branchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzoe*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, nonpenicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinory tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior ta results of sensitivity testing.

Contraindicatians Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin shauld anly be prescribed far the indications listed herein.

Cyclacillin has less in vitra activity than ather drugs af the ampicillin class. However, clinical trials demonstrated it is efficacious far recommended indicatians.

Seriaus and accasional fatal hypersensitivity (anaphylactaid) reactians have been reparted in patients an penicillin. Althaugh anaphylaxis is more frequent following parenteral use, it has accurred in patients an aral penicillins. These reactians are mare apt to accur in individuals with histary af sensitivity ta multiple allergens. There are reparts af patients with history af penicillin hypersensitivity reactions wha experienced severe hypersensitivity reactians when treated with a cephalasparin. Before penicillin therapy, carefully inquire abaut previaus hypersensitivity reactians ta penicillins, cephalasparins and ather allergens. If allergic reactian accurs, discontinue drug and initiate appropriate therapy. Seriaus anaphylactaid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubatian, should also be administered as indicated.

Precautians Prolonged use of antibiotics may promote overgrowth of nonsusceptible orgonisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dase revealed no evidence of impaired fertility or harm to the fetus due ta cyclacillin. There are, however, na adequate and well-controlled studies in pregnant wamen. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise cautian when cyclacillin is given ta a nursing waman.

Adverse Reactians Oral cyclacillin is generally well tolerated. As with other penicillins, untaward sensitivity reactions are likely, particularly in those wha previously demanstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reparted with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vamiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isalated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reparted with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible an discantinuatian af therapy.

As with other semisynthetic penicillins, SGOT elevations have been reparted.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and passibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due ta prolanged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dasage (Give in equally spaced dases)

INFECTION	ADULTS	CHILDREN*
Respiratary Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild ar Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chranic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 ta 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 ta 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dasage shauld nat result in a dase higher than that far adults.
†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles af 100. Oral Suspensian 125 mg and 250 mg per 5 ml in bottles ta make 100 ml and 200 ml af Suspension.

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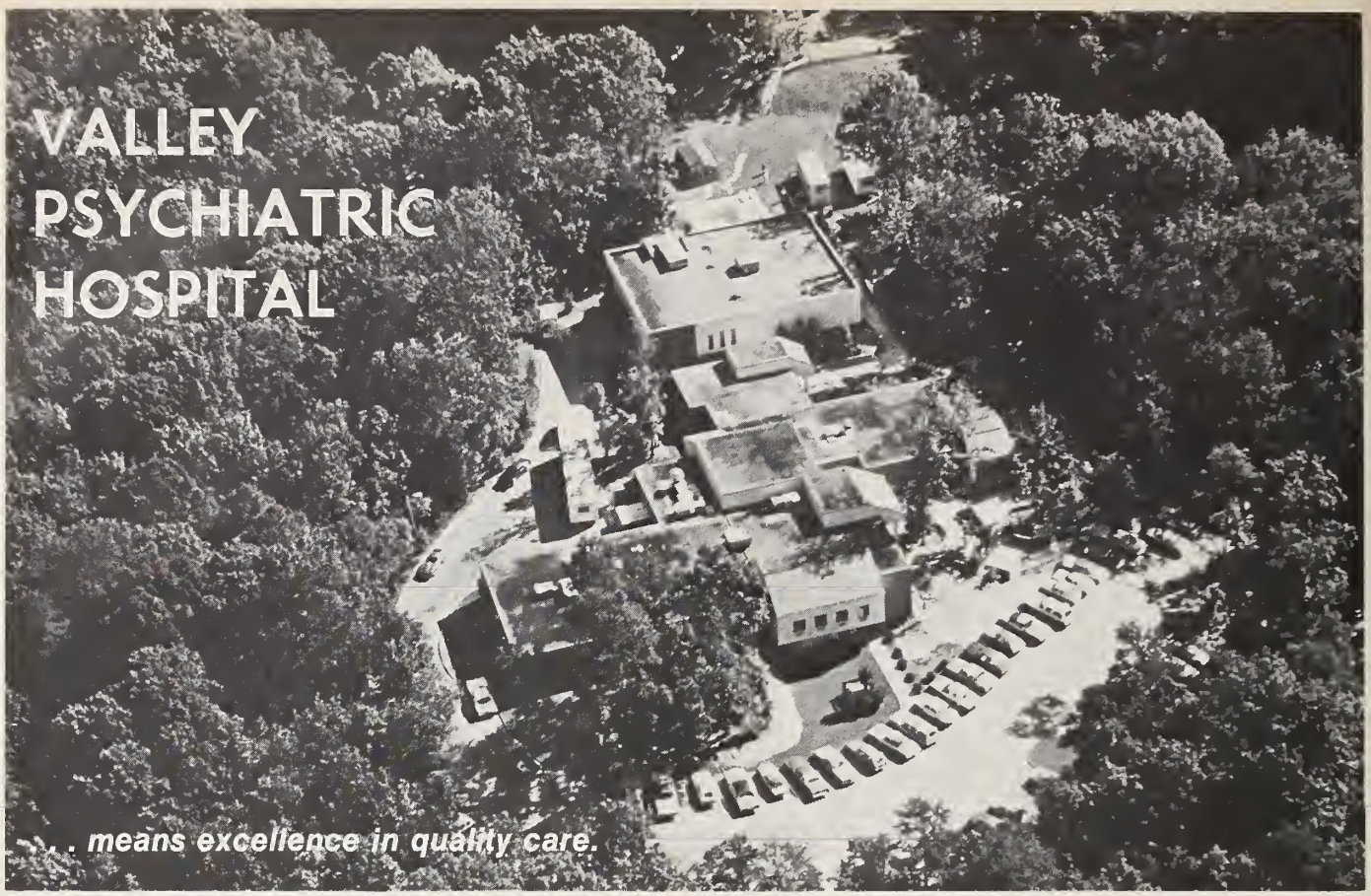
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Do you want to buy a boat? Or sell some office equipment? Or find a new associate? Or rent a vacation home? The ***Journal*'s Classifieds** is the inexpensive way to get your message with thousands of others who share your professional and recreational interests.



Valley is a fully accredited private psychiatric hospital staffed by professionals with outstanding credentials in the field of mental health and emotional disorders.

The carefully coordinated team approach includes intensive individual and group psychotherapy, and expressive therapy for the patient whose condition requires evaluation and professional treatment.

Valley is a 100-bed private psychiatric hospital nestled in an 81-acre wooded area on the outskirts of Chattanooga, Tenn. Structured clinical programs include:

ADULT PSYCHIATRIC PROGRAM—Admission to the adult program at Valley involves diagnostic procedures such as complete physical examination, psychological testing, psychiatric evaluation and review of social history. Based upon results of these initial tests, the patient's attending psychiatrist together with members of the psychiatric treatment team develop a total treatment plan which may include group therapy in addition to individual therapy, occupational and recreational therapy as well as family involvement.

Weekly meetings of the treatment team are held to modify the original treatment plan based on the patient's progress while in the hospital.

CHILD AND ADOLESCENT PROGRAM—Valley maintains a child and adolescent program for youngsters undergoing specific difficulties in growth and development. This program provides individual as well as group therapy and includes activities in art, sports and field trips of special interest to this age group.

An active school experience is part of this program. Individual lesson plans, administered by special education teachers and worked out with the children's own school district educators, keep them from falling behind peers in their own community school. Because the student is allowed to move at his own pace in an individualized program, he develops confidence and self-discipline.

The Valley program regards adolescence as a psychological growth process—not a disease—so that time, skill and experience are critical ingredients of the treatment.

SUBSTANCE ABUSE PROGRAM—This treatment team is trained and experienced in the treatment of alcoholics and other drug-dependent persons.

A number of approaches are used in the treatment of alcoholism and/or drug abuse: individual and group therapy, substance abuse counseling, lectures, communication skills training, pastoral counseling, physical and recreational therapy, the 12 Steps of Alcoholics Anonymous, Antabuse therapy, and various forms of adjunctive therapy. Whenever possible, family members are urged to become involved in the patient's treatment through out-patient family and individual counseling.

REFERRAL—Valley maintains a 24-hour, seven-day-a-week emergency referral service. Referrals are accepted from psychiatrists and other physicians, the clergy, social workers, mental health professionals, social agencies, self and family.

Valley is fully accredited by the Joint Commission on the Accreditation of Hospitals.

Robert G. Aug, M.D., Medical Director
Susan McGuire, M.D., Medical Director of the Child and Adolescent Program
Carroll J. Carter, A.C.S.W., Director of the Alcohol and Drug Treatment Program

VALLEY PSYCHIATRIC HOSPITAL
P.O. Box 21886 • Shallowford Road
Chattanooga, TN 37421-0886
(615) 894-4220

A position statement by the Georgia Thoracic Society to clarify the requirements for this procedure.

Fiberoptic Bronchoscopy

GARNETT J. GIESLER, JR., M.D, *LaGrange**

This position paper was developed by the Standards Committee of the Georgia Thoracic Society at the request of the society's Executive Committee. It represents the official position of the Georgia Thoracic Society regarding necessary qualifications for performing fiberoptic bronchoscopy.

FIBEROPTIC BRONCHOSCOPY is a relatively new procedure in this country, and it has become increasingly popular in the past 10 years. It involves the use of a number of reflecting glass rods in a small flexible tube with varying internal diameters. The instrument provides a wide range of visibility in virtually any direction. It is particularly valuable in viewing segments and subsegments of the pulmonary anatomy where direct visibility had previously been very difficult, i.e., in the upper lobes of both lungs. The biopsy forceps which are used with the fiberoptic instrument are distinctly different from those used with a rigid bronchoscope. Therefore, different complications must be anticipated with the use of this instrument.

The successful performance of fiberoptic bronchoscopy requires excellent eye-hand coordination, a thorough knowledge of pulmonary anatomy and physiology, and a knowledge of the potential complications and the capability of dealing with them. One distinct difference between this procedure and rigid bronchoscopy is that the former often involves a biopsy of lung parenchyma. This has as inherent risks such complications as pneumothorax, pulmonary hemorrhage, etc., which are not commonly associated with rigid bronchoscopy.

* Dr. Giesler is Medical Director, Pulmonary Medicine Department, West Georgia Medical Center, and Chairman, Standards Committee, Georgia Thoracic Society. Other committee members involved with the preparation of this paper are: Alan L. Plummer, M.D., Ralph L. Haynes, M.D., William R. Kenny, M.D., and David G. Tinkelman, M.D. Address reprint requests to Dr. Giesler at 303 Smith St., LaGrange, GA 30240.

The average time required for fiberoptic bronchoscopy ranges from 15 minutes to 1 hour. The fiberoptic bronchoscope is a very delicate instrument and costs approximately $6,000. It can be easily damaged by any acute bend in the glass rods, and the average repair time requires in excess of 6 weeks. The fiberoptic bronchoscope can be used for numerous bronchoscopic procedures if it is handled by persons fully acquainted with its intricacies and potentials for damage.

It is inaccurate to include within the term "bronchoscopy" both the rigid and fiberoptic procedures, since they are distinctly different in a number of ways. These procedures should be listed separately on credential application forms, and documentation of training in these separate areas should be provided by the proposed bronchoscopist. This more specific definition is in order to protect the quality of fiberoptic bronchoscopy programs and to protect the hospital's investment in fiberoptic instruments.

Proposed Criteria for Use of Hospital Credential's Committees in Granting Privileges for Performance of Fiberoptic Bronchoscopy

A. The training program shall include a complete and in depth experience in fiberoptic bronchoscopy to the extent that:
 1. The trainee has observed a significant number of fiberoptic bronchoscopies performed by an experienced fiberoptic bronchoscopist in a certified training center for chest disease and has actively assisted in these procedures.
 2. The trainee has performed under the direct supervision of a qualified fiberoptic bronchoscopist an acceptable number of these procedures and is certified by the director of the program to be competent in his/her performance.
 3. That the training program director state in

writing to the hospital Credential's Committee to which an applicant has applied that he/she is fully trained and competent in all areas of fiberoptic bronchoscopy and is knowledgeable of the potential complications and their management.

B. For physicians already in practice, the following training criteria are suggested for granting fiberoptic bronchoscopy privileges:
 1. Successful completion of a training program in the use of the fiberoptic bronchoscope as sponsored by either the American College of Chest Physicians or the American Thoracic Society and certification by either organization.
 2. A statement from the course director of the training program mentioned above to the Credential's Committee of the hospital to which the physician is applying for fiberoptic bronchoscopy privileges, stating that he/she has successfully completed the training program and is competent in the performance of that procedure.

It is the hope of the Standards Committee of the Georgia Thoracic Society that hospital and medical centers within Georgia use certified fiberoptic bronchoscopists as advisors when questions arise concerning adequate training programs. A quality program requires periodic medical audits to assess indications for the procedure, complication rates, and sensitivity of this important medical tool.

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ADOLESCENT THERAPY PROGRAM





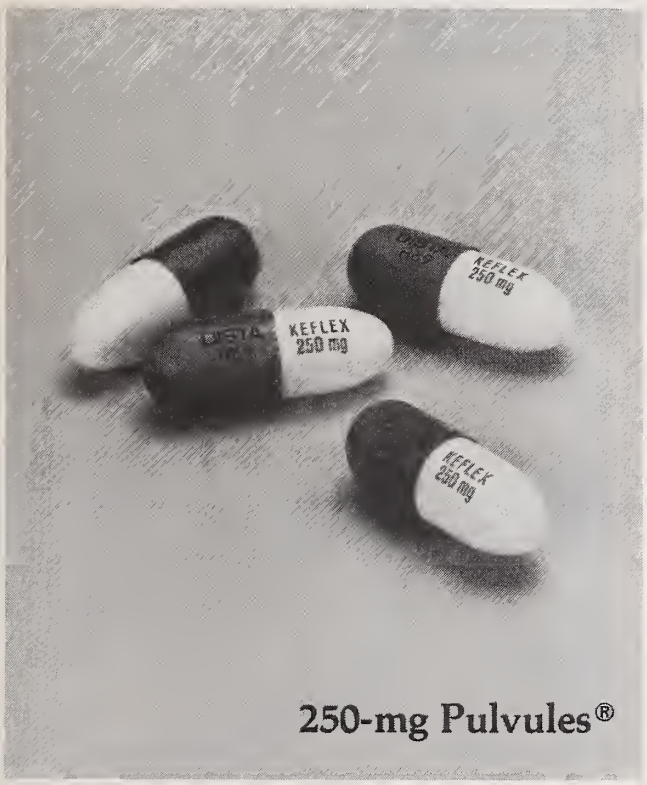
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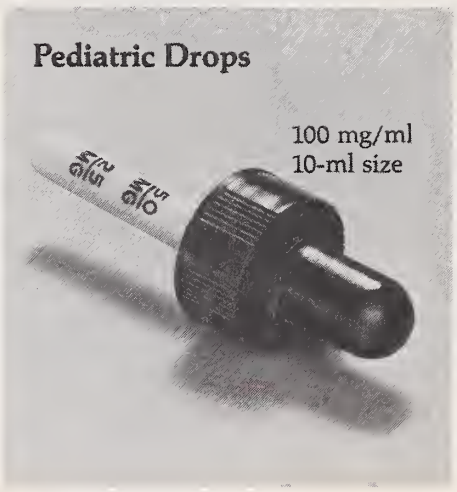
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In the treatment of impetigo–

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus,* 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes,* and 1% beta-hemolytic *Streptococcus.*‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:
Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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editorial
editorial
editorial

PIP — A Most Important House Call

"Involvement . . . is essential to our living."
Anonymous

WHAT DIFFERENCE does it make if physicians show their faces at the state Capitol? Read these comments from legislators:

"Why are there so many doctors here today?"
"What does the Medical Association want, that you've got so many doctors around?"
"What are you planning since you've got the troups out?"
"Is this program going to last all session?"
"I've never seen this many doctors at one time in my life!"

For the answer to "why be involved?," we must look to our friends from Missouri with their meaningful state motto — Show Me. It is impossible to send a representative to be involved for you. And to the legislature, without the "show me" ingredient, you go without.

The Physicians Involvement Program (PIP) *is* physicians actively involved in the legislative process, thanks to H. Hilt Hammett, Jr., M.D., of LaGrange, who proposed it. After only 1 year of operation, it is one of the most important facets of MAG's legislative activities. This program, which brings physicians to the state Capitol every day while the General Assembly is in session, is an organized, professional, and effective means to communicate the views of organized medicine. It is a most innovative lobbying effort, as evidenced by the desire of other groups to copy it — both in Georgia and elsewhere in the nation.

This program, beginning its second year, accomplishes two primary goals of the MAG. First, it enables our members to become more knowledgeable of and more informed in the legislative process in Georgia. Secondly, it serves to enhance our communications with members of the General Assembly. This organized effort, combined with the work of the legislative activities staff, is a powerful mechanism to accomplish the objectives of the physicians of the state.

To say that the 1981 PIP was successful is an understatement. The comments that follow are from physicians who participated last year in this valuable effort:

Mark A. Gould, M.D., Psychiatry, Atlanta — The Medical Association of Georgia's PIP at the Georgia legislature offers an outstanding opportunity to get involved in the political process. This program places MAG members in the midst of the legislative experience, and it is there that the members can actively observe the process as the legislature and its committees are in session. Participants can learn how to do effective lobbying by watching those efforts, as well as actually meeting members of the legislature. The hesitancy of physicians to get involved in these activities is often secondary to their discomfort over being ill prepared and

unaware of the issues. This program is the most effective means which I know that can help overcome that kind of resistance. Physicians can no longer afford the luxury of leaving these activities to someone else. It is more important now than ever before that MAG members place themselves on the front line of the political process. I consider PIP to be an excellent way to step into the action.

Hugo S. Moreno, M.D., OB/Gyn, East Point — Last January, I had the opportunity to attend . . . the Georgia General Assembly . . . under the auspices of the MAG. It was a very rewarding experience not only because it gave me an inside view of how the legislative process works, but also to see how legislators are so pleasantly surprised to see busy M.D.s taking time off to let them know that *we were there,* interested in any legislation that may affect us and the health care of the people in Georgia. I saw that first hand when I approached two of the legislators from my district to invite them for lunch and discuss some pending bills. I really think that a few hours per year spent there by each of us go a long way in reaching the goals of organized medicine.

H. Hilt Hammett, Jr., M.D., Ophthalmology, LaGrange — To communicate is to understand. To understand is to reason together. To reason together is to trust and find unity of purpose.

Our experience during the 1981 Georgia General Assembly with our PIP reinforced that positive position. The daily presence and participation of increasingly large numbers of our members opened avenues of communication with our legislators that have been beneficial to our patients and to our profession. Through the continued activity of our membership in this valuable modality, the health care of our citizens will receive important priorities.

It has been said that the only thing wrong with democracy is our failure to use it. I respectfully and sincerely urge our membership to actively participate in our Physicians Involvement Program. It is not only our responsibility to do so, it actually provides an outstanding opportunity to learn, to communicate, and to be effectively productive.

George S. Heath, M.D., Family Practice, Waycross — . . . I much enjoyed my visit to the state Capitol. I was already well acquainted with my legislators and enjoyed seeing them again. I was most interested, however, to learn of the details of the MAG activities in the legislature. I will be glad to participate again.

Milton I. Johnson, M.D., Family Practice, Macon — Participating in PIP is an exhilarating experience for a physician. It is also the duty of physicians to learn the ways of politics and to influence them toward the public good in health care matters.

Your local state senator and representative responds to local input more than to any petition or lobbyist. If they get input from the wrong people, they pass bad legislation. It's up to us.

Eloise Sherman, M.D., Pathology, Savannah — Shakers and makers on the move! Organized, collaborating, unified. Voters, constituents, "We the people." Hey, Mr. Legislator, let me tell you something about that bill in the hopper. O.K., Doc, you're the expert. Stimulus, challenge, camaraderie. Where in thunder did all those Capitol Docs come from? Briefcases, green badges, MAG, that's me. My Dad did too help pass that law! Your interest, my interest, *our* interest. Helping, trying, *DOING SOMETHING* — for now, tomorrow, and before '84. Hand shaking, back slapping, glad to metcha, my name is ____. You're the boss, it's your General Assembly. Try it, it works, it's a high — it's a *PIP!*

Hugh O. Hodges, M.D., Family Practice, Winder — The day I spent at the Capitol in Atlanta with the MAG PIP was definitely a worthwhile experience — so much so that I plan to participate again this session. The time spent at the Capitol to me was informative, productive, and exciting. I was able to see the legislative process in action, and I was also able to meet with several of the legislators to discuss

impending legislation. I trust I had a part in swaying the legislators' thinking to the MAG stand. I was well-briefed as to which bills were the most important and how to most effectively communicate with representatives and senators.

Building on the success of last year's effort, when over 300 physicians participated, the 1982 PIP promises to be even better. One day is certainly a small contribution, but the combined efforts of all the participants make the MAG's voice loud and clear.

The PIP day begins with an orientation program at the Stadium motel near the Capitol. After a discussion of the issues and an explanation of the days' events, the group then goes to the Capitol to meet with their legislators and attend committee meetings and sessions of the House and Senate.

Don't pass up this opportunity to become involved. Joining is easy. Contact Carol Greene at MAG headquarters (PH: 404-876-7535 or 800-282-0224) and your part in the 1982 General Assembly will be assured.

James Kaufmann, M.D.
Internist, Atlanta

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MAG staff

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Cancer Pain and Chronic Illness

STEVEN F. BRENA, M.D., and
KATHLEEN B. WALLACE, R.N., M.N., *Atlanta**

In the last decade, research has presented overwhelming evidence that biological abnormalities and illness behaviors are independent variables.[1, 2] An "illness (or pain) behavior" may be defined as follows: (1) pain complaints; (2) inactivity; (3) drug misuse; (4) dependency; (5) loss of self-reliance. The World Health Organization has acknowledged such research findings by changing the definition of health, which is no longer conceptualized as "absence of disease" but as "a state of complete physical, emotional, and social well-being." This definition implies important changes in the health delivery system. In complex cases of prolonged illness, disease-oriented medical intervention must be supplemented by behavior medicine to provide patients with skills to cope with the chronic illness and possibly to return to and maintain a state of health.

The last decade has also witnessed radical changes in our knowledge of pain as a complex biologic, emotional, and social phenomenon. Research findings have shown that acute pain (i.e. pain related to a biologic derangement of recent onset) is quite different from chronic pain (i.e. pain of long duration, mostly associated with

The correction of biologic abnormalities must be viewed within the framework of the new [WHO] definition of health, in balance with proper rehabilitation training, once the pathologic factors have been stabilized.

chronic illness and/or emotional maladjustment). While acute pain is probably subserved by an overload of nociceptive stimulation along peripheral nervous pathways following acute injury or disease, chronic pain is presently viewed as a likely breakdown of pain-inhibitory mechanisms, with repetitive, abnormal firing in the central pool of neurons and conditioned responses poorly related to actual peripheral nociception.[3] In managing patients with chronic illness, such as cancer patients, the health professional must be aware of this changing knowledge in order to fulfill his/her obligations toward the patient. The correction of biologic abnormalities must be viewed within the framework of the new definition of health, in balance with proper rehabilitation training, once the pathologic factors have been stabilized. In 1978, a publication from the Department of Physical Medicine and Rehabilitation of the University of Washington has shown that over 40% of patients

* Dr. Brena is a Professor and Director of the Emory University Pain Control Center, and Ms. Wallace is Assistant Professor, Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, GA 30322. Send reprint requests to Ms. Wallace.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

with cancer are excellent candidates for rehabilitation.[4] Proper rehabilitation training of the patient with pain means teaching him/her how to manage the pain problem. One of the key issues in successful pain management is "helping the patient help himself." The health professional must realize that the person who has pain is in a dependent state, and that such dependency, or "learned helplessness," is a factor of the suffering experience. By training the sufferer to achieve a sense of independence despite the diseased state, a decrease in the suffering itself is likely to follow. Teaching the patient to successfully manage a pain problem means spending time with him/her and sharing knowledge of physical and emotional factors which may influence the painful experience. It also means informed training in the use of current methods for pain control. For instance, patients need information about the pharmacology of the drugs they are taking. An admonition about their addiction potential does little to assist the patient in increasing his/her knowledge about how to take the drug in order to ensure efficacy and decrease side effects and dependence.

To be successful in managing patients with chronic pain, physicians themselves need to be informed about updated research and clinical findings about the neurophysiology and the psychology of pain and be familiar with the various available analgesic techniques, such as the proper use of transcutaneous electrical nerve stimulation (TENS), the changing roles of nerve blocks, the proper roles of active physical therapy and occupational therapy, and the newer neuro-surgical techniques for pain control in terminal malignancy.

In summary, in non-terminal cases of malignancy, the medical intervention for control of tumor growth must be balanced through behavioral medicine to maintain or reestablish health behavior. The principles of cancer rehabilitation may be presented as follows: (1) to correct opiate overdose and other possible drug misuse; (2) if drug therapy is necessary, it must be planned on a time contingency basis, *never on a PRN basis,* to avoid or delay dependency; (3) to restore comfortable levels of activities of daily living; (4) to restore self-reliance by correcting emotional and social factors which may reinforce dependency; (5) to provide instruction for self-control of pain; useful skills to cope with chronic pain are: progressive relaxation, breathing exercises, self-hypnosis, and the use of imagery. Even in cases of terminal malignancy, a behavioral medical intervention may still be useful to provide patients with some of the above mentioned alternatives other than opiates and sedatives to deal with their terminal illness behaviors.

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Availability of Jury Duty Exemptions for Physicians

JANE M. HAVERTY, *Atlanta**

As soon as a physician receives a summons to appear for jury duty, his immediate reaction may be irritation at having to cancel and reschedule his appointments, find adequate temporary substitutes, or recommend other physicians to his patients and risk possible financial loss. Moreover, once at the courthouse to perform his "civic duty," he may find that most of his time is spent sitting around, waiting. Shouldn't a physician be able to be exempt from jury duty?

To answer this question, one must first look to the history of the right to a trial by jury. Part of our heritage from England, this right was so highly regarded by the Founding Fathers that it was guaranteed by the Bill of Rights in the U.S. Constitution, and similar guarantees are found in the Constitutions of practically every state. Our notions of what constitutes a proper jury thus developed in harmony with our basic concepts of a democratic society and a representative government. The concept has come to presuppose a jury of one's peers, drawn from a pool of persons broadly representative of one's community.

In certain respects, however, that concept has come to have a different meaning in the federal and state courts. In Georgia, the state courts *exempt* physicians from that "pool of persons," whereas the federal courts only allow a physician to be *excused* from jury duty on individual request.

Availability of Jury Exemptions in Federal Courts

From the adoption of the U.S. Constitution in 1789 until 1948, Congress made few inroads into the discretion of federal judicial officials and state governments in the development and application of jury qualifications. Congress in the first judiciary acts selected for the federal courts the qualifications and exemptions prescribed by the state in which each federal court sat.[1]

In 1948, Congress enacted a Judicial Code[2] which adopted uniform standards of qualifications, exemptions, and disqualifications for jurors in all federal courts. Out of deference to the states, however, and in an effort to avoid controversy, Congress chose to disqualify for federal jury service all persons who were incompetent to serve on juries in the state in which each federal court sat. Therefore, while there was theoretically one uniform set of federal qualifications, the divergent laws of the several states still imposed 48 separate standards for federal jury service.

The Civil Rights Act of 1957 had the effect of amending that Code by removing all reference to state qualifications. It was thought that, by adopting one uniform set of federal jury qualifications to be applied as the single national standard, the incidence of racial discrimination in jury selection could be decreased, and those

* Prepared at the request of the Medical Association of Georgia. Ms. Haverty is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

serving on federal juries would better reflect a fair cross section of the community. However, neither the 1948 Judicial Code nor the Civil Rights Act of 1957 completely eliminated the possibility that different statutory standards of qualification would be applied in different federal courts because some discretion remained divested in the hands of the clerks and the jury commissioners in the compilation of the jury lists.[3]

The purpose of the Jury Selection and Service Act of 1968[4] was to provide an improved judicial machinery for the selection, without discrimination, of federal juries. It does so by providing (1) random selection of juror names from voter lists of the district or division in which court is held, and (2) determination of juror disqualifications, excuses, exemptions, and exclusions on the basis of objective criteria only. Congress thought that these changes would provide the best method of obtaining jury lists that represent a cross section of the relevant community and would establish an effective bulwark against impermissible forms of discrimination and arbitrariness. The changes were also designed to enhance jury performance.[5]

The current federal law with respect to the availability of jury duty exemptions for physicians is based upon this Act, as amended.[6]

In Georgia, the state courts* exempt *physicians from that "pool of persons" [representatives of the community], whereas the federal courts only allow a physician to be* excused *from jury duty on individual request.

28 U.S.C. §1863 provides that each district court shall devise a "plan for random jury selection" which may specify groups whose members may be *excused* or *exempt* from jury service. The drafters of the statute felt that the specification of particular groups which could justifiably avoid jury service would make it difficult for members of the community who do not fall within those groups to avoid service on spurious grounds. "Many professional and business people now easily avoid service on the ground that they are 'busy people.' Some will still be able to obtain individual excuses when they are under genuine hardship, but the casual granting of excuses to these presumably more intelligent members of the community will no longer be possible. Enhanced jury performance, as well as enhanced community cross-section will be the result."[7]

Nevertheless, this plan does provide some flexibility so that each locality may adjust the administration of jury selection to their particular needs. Physicians are one "group" which each district may, at its discretion, identify as one of those "occupational classes" whose members may, on individual request, be *excused* from service. However, there must be a finding that service by such a group would entail "undue hardship or extreme inconvenience to the members thereof" and that excuse upon individual request would not be inconsistent with the basic policy of the statute.[8]

As the State of Georgia is divided into three distinct federal districts, the Northern District (which includes Atlanta), the Middle District (Macon), and the Southern District (Savannah), three different local plans have evolved.

In the Northern District, the jury plan adopted does provide for "all actively practicing attorneys, physicians, dentists, and registered nurses" to be excused from jury service on individual request.[9] However, apparently in an effort to strictly adhere to the policies of the 1968 Act, the courts have tacked on an additional requirement. When a physician receives a summons to serve, he must request, in writing, to be excused and must state a specific date when he or she can serve. If an alternate date is not specified, the original summons remains in effect, and the physician will be required to serve at the originally designated session.

In contrast, the jury plan of the Middle District of Georgia, recently revised and approved as of the summer of 1981, is a little more lenient. When a physician receives a juror qualification form, he may indicate thereon that he wishes to be excused. His name is then automatically removed from the jury box, the list from

which names are subsequently drawn for assignment to jury panels. He would thus not receive a summons. However, if for some reason the physician neglects to indicate on the questionnaire that he wishes to be excused, or if events occur which would prevent him from being able to serve, he may submit a written request to be excused at such time as he is summoned. He need not specify an alternate date.

Originally, physicians in the Southern District were automatically excused as they are now in the Middle District. However, because a physician may be excused only on "individual request," a recent amendment to the local court rules requires that a physician first be summoned. He may then write a letter to the judge of the court to which he was summoned, requesting to be excused.[10] Again, he need not specify an alternate date. However, in contrast with the policy followed in the Middle District, once a physician is excused, his name is placed back in the jury box so that he may be summoned at a later date. This is a new procedure for the Southern District and, accordingly, the mechanics of the plan are still developing. Apparently, there has not yet developed any opposition to physicians being excused.

Availability of Jury Exemptions in State Courts

In contrast to these federal rules, state law does *exempt* physicians from jury service. Pursuant to *Ga. Code Ann.* §59-112(a)(4), physicians, surgeons, medical interns, and medical technicians actively engaged as such are exempt, not just excused. Accordingly, the name of any such person is not included or continued in the jury box unless that person makes a special request, in writing, to the Board of Jury Commissioners or the clerk to be included. In addition, the personnel of a hospital may be exempted if the administrative head of the hospital certifies to the Board of Jury Commissioners that these personnel are "indispensable" to the effective operation of the hospital

However, in some counties, a different procedure for exempting physicians is followed. Pursuant to *Ga. Code Ann.* §59-112.1 entitled, "Alternate Provisions for Exemptions from Jury Duty," in any county which has established a plan for the selection of jurors by electronic or mechanical means, the chief judge of that county's Superior Court may rule that the provisions of this alternate section will apply in lieu of the provisions of §59-112. If he does so, the names of physicians, surgeons, etc. remain on the jury list, but such persons may exempt themselves from all jury duty upon written request to the clerk of the court.

Fulton County, as one example, has apparently adopted this alternate plan. The clerk sends out questionnaires to all persons on the voter registration list. When a physician answers the questionnaire, he may claim the exemption, and his name will not be placed on the jury list. If the exemption is not claimed on the questionnaire, then the physician's name will be placed on the jury list. When he receives a summons to serve, however, he may send a letter or notice to the jury clerk stating that he is a physician, in which case he will be exempted from service.

Although this exclusion of physicians has been challenged, the courts have generally upheld the special treatment, be it as an exclusion or an exemption. It is conceded that physicians are among those persons likely to suffer the greatest hardships because they may have difficulty finding adequate temporary substitutes when they leave their practice, or may incur extra work or financial loss even if substitutes are obtained.[11] However, both the need for competent jury panels and the need for a fair cross section of the community are important considerations.

The distinction between federal and state law regarding exemptions for physicians reflects to a certain extent the more activist position taken by the federal judiciary in the field of jury selection. Accordingly, there appears little likelihood that the federal rules will be changed to allow a blanket exemption for doctors. The prospects for change in the state courts are less clear. Ultimately, the issue is one of balancing the need for competent juries selected from a representative cross section of the community against the need to provide efficient and uninterrupted medical care. *(List of footnotes furnished on request.)*



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WARNINGS: Anaphylactoid reactions have occurre in patients hypersensitive to aspirin (see CONTRAIND CATIONS). Peptic ulceration and gastrointestin bleeding, sometimes severe, have been reporte Peptic ulceration and gastrointestinal bleeding, som times severe, have been reported. Peptic ulceratio perforation, or gastrointestinal bleeding can end fatal however, an association has not been establishe Rufen should be given under close supervision to patien with a history of upper gastrointestinal tract diseas and only after consulting the ADVERSE REACTION

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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president's letter



The Hospital Bed Occupancy Game

The North Central Georgia Health Systems Agency (NCG-HSA) held a public comment hearing recently before its Task Force on Hospital Bed Need. Written comments had already been presented by many of the hospitals in the NCG-NSA area, and another dozen made oral presentations at the meeting. Most of the hospitals contended that NCG-HSA projections of their bed occupancy rates for the next 5 years were far too low. They showed their own projections which indicated much higher occupancy rates and in some cases, demonstrated potential need for additional beds to be constructed.

Most hospital administrators today are articulate, well trained, and understand bureaucracy very well. They especially understand that hospital beds are filled by doctors who practice nearby and find their hospital a satisfactory place to work. Specialists and family practitioners alike are being actively recruited by rural hospitals benefitting from the ever increasing number of doctors coming into practice. Apparently, if one adds a cardiologist, an orthopedist, and an internist to a rural staff, the census inevitably increases.

You might think at first that the larger referral and teaching hospitals would admit to a decline in occupancy rates. This is not the case, it seems, since these hospitals also make a strong argument that their occupancy rates are also increasing and that they are having to keep their sicker patients longer, while providing ever greater intensity of care. These claims are being made also at a time of increasing use of out-patient surgical and diagnostic services in the NCG-HSA area.

It will be interesting to see where the growth of use and services really will predominate in the next 5 to 10 years. The only safe predictions I can make are that the area hospitals will be increasingly competitive and that the health planners will probably make the wrong predictions.

L. Newton Turk, III, M.D.

L. Newton Turk, III, M.D.
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PERSONALS

First District

As of Oct. 1, **Edward F. Downing, M.D.,** of Savannah, has assumed the chairmanship of the Cerebrovascular Section of the American Association of Neurological Surgeons. Dr. Downing is a 1963 graduate of Tulane Medical School and received specialty training at the Neurological Institute of New York and the National Hospital for Nervous Diseases in London, England.

In an article written Oct. 27 in the Hinesville newspaper, **Whitman Fraser, M.D.,** praised his nursing staff at the Liberty Memorial Hospital and generally noted that improvements in nurse training today have produced quality professional nurses. Dr. Fraser and the chief nurse of the hospital had begun a series of conferences to discuss approaches to foster better communication between doctors/nurses in order to successfully deal with the "changing" doctor-nurse relationship.

Curtis G. Hames, M.D., family physician from Claxton, was honored in November at a recognition program at the Medical College of Georgia, by the naming of its first distinguished "Chair."

Dr. Hames opened a practice in Claxton after graduating from MCG in 1944. In recognition of his research efforts in high blood pressure, heart disease, and nutrition, Dr. Hames was named consultant to the National Institutes of Health and advisor to the World Health Organization. Also, he was appointed to the faculties of MCG, the Universities of South Carolina and North Carolina, and the Medical University of South Carolina.

One of Dr. Hames' current research projects is an international study with China, Finland, and the U.S. concerning the importance of the trace metal selenium in relation to cardiovascular diseases.

Specialist in general surgery, **Archie J. Morris, Jr., M.D.,** Vidalia, was named Fellow of the International College of Surgeons at a ceremony held during the annual meeting of the U.S. Section of the International College of Surgeons in Coronado, CA, on Nov. 19.

Fourth District

Last October, **Charles Allard, M.D.,** of Decatur, chairman of the MAG's Prison Health Committee, presented a Certificate of Accreditation to the Montgomery Correctional Institution at Mt. Vernon, the first prison facility in Georgia to receive such accreditation.

W. Frank Matthews, M.D., chief of the department of pathology at DeKalb General Hospital in Decatur, was re-elected governor of the 8,800 member College of American Pathologists. Dr. Matthews was re-elected to a second 3-year term at a recent national meeting of the college.

Terrell Tanner, M.D., Oxford family practitioner, was again elected as chairman of the Ga. Academy of Family Physicians' Commission on Education at their annual meeting Nov. 5.

Fifth District

Earnest C. Atkins, M.D., of Decatur, was recently elected chief of the department of surgery at DeKalb General Hospital. Dr. Atkins has been a member of the hospital's staff since 1961.

Pathologist **John T. Godwin, M.D.,** of Atlanta, conducted the recent annual meeting of the Memorial Hospital Alumni Society, New York City, of which he is immediate Past President. Dr. Godwin returned for the meeting from Riyadh, Kingdom of Saudi Arabia, where he is on sabbatical. He is serving as chairman of the department of pathology and laboratory medicine of the King Faisal Specialist Hospital and Research Center. Also, he is a member of the Cancer Treatment Center, chairman of the Tumor Registry, and member of the editorial board of the hospital's *Journal.*

Contraception expert and director of the Emory University Family Planning Program, **Robert A. Hatcher, M.D.,** won the 1981 John D. Rockefeller III award for outstanding "contributions to families and youth." The $10,000 award presentation was made Dec. 8 in Washington, D.C. Considered a leading world authority on contraception, Dr. Hatcher is the author of a book entitled *Contraceptive Technology.*

Spencer B. King, III, M.D., director of Emory University Hospital's cardiovascular laboratory, is one of six physicians participating in experimental testing and use of a clot-dissolving drug—streptokinase—with heart attack victims. Heart attack patients arriving at Crawford W. Long Memorial Hospital in Atlanta are asked if they wish to receive injections of the experimental drug so that Dr. King and other participating physicians may determine if the medicine reduces heart muscle damage.

Louis W. Sullivan, M.D., president and dean of the Morehouse School of Medicine in Atlanta, addressed the Thomasville Rotary Club last November.

Sixth District

Paul R. Coplin, M.D., of Macon, was interviewed in a recent feature article on pain published in the Milledgeville newspaper. Dr. Coplin practices medicine at the Psychiatric Associates of Middle Georgia and has opened a branch office in Milledgeville.

Seventh District

At the recent 1981 annual meeting of the Southern Psychiatric Association held in Nashville, TN, **Mark A. Gould, M.D.,** presented a paper on the "Impact of Leg-

islation on Inpatient Care.'' Dr. Gould is medical director of Brawner Psychiatric Institute and president-elect of the National Association of Private Psychiatric Hospitals.

Parkway Regional Hospital in Lithia Springs added several new doctors to its staff in October. MAG members include pediatrician **Eduardo Montana, M.D.,** of Marietta, and surgeon **Neil Negrin, M.D.**

Orthopedic specialist, **William C. Stem, M.D.,** of Cartersville, was the guest speaker at the October meeting of the Cartersville Optimist Club. Dr. Stem spoke about orthopedics — advances and breakthroughs — and the general status of health services in the community.

Eighth District

On May 1, 1982, the Glynn Emergency Clinic in Brunswick, a new medical facility, is scheduled to open. Emergency medicine physicians, **Jesse Hunt, M.D., Robert Miller, M.D.,** and **Lynn Hicks, M.D.** will be on the staff. They announced plans for the opening last November.

Philip R. Saleeby, M.D., of Brunswick, addressed the Glynn County Civic Association in November on the topic of air pollution. Dr. Saleeby is campaigning actively in the community against air pollution.

A new group practice, Wayne Family Practice Associates in Jesup, was opened last October by three physicians. **Thomas M. Williams, M.D.,** urologist, and **J. Greg Varnadore, M.D.,** family practitioner, are the MAG members associated with the new group.

Ninth District

John E. Fowler, M.D., of Clayton, was elected vice president of the Ga. Academy of Family Physicians on November 5.

Tenth District

In recognition of his community service, **James B. Kay, Jr., M.D.,** of Augusta, was named a Paul Harris Fellow by the Rotary Club of Augusta. It is the highest award given by the Rotary.

Charles E. Wills, Jr., M.D., of Washington, was recertified as a Diplomate of the American Board of Family Practice. ABFP Diplomates must pass an examination every 6 years to maintain specialist status.

NOTABLES

The following family physicians were recognized by the American Academy of Family Physicians (AAFP) at the 1981 annual convention and scientific assembly held September 21, 1981, in Las Vegas for their 25-year membership and service in the AAFP: **W. Justus Gower, Jr., M.D.,** Thomaston; **Richard L. Smith, M.D.,** Cochran; **Irving D. Hellenga, M.D.,** Toccoa; and **Henry G. Davis, Jr., M.D.,** Sylvester.

The 3rd annual **Medical Fair** held October 22-24 in Augusta was a success. The Fair is a physician and dentist recruitment program for rural areas in Georgia. Over 40 communities were represented and over 100 residents attended the Fair.

In Toccoa, friends of the late **Wade Knowlton, M.D.,** established a scholarship fund in his honor.

DEATHS

Edwin W. Allen, Jr.

Edwin W. Allen, Jr., M.D., died November 8 at the age of 59. He had been a member of the Baldwin County Hospital staff since 1957 where he served as medical director of the cardiology department for several years.

Survivors include his wife, his parents, four sons, three daughters, one brother, a sister, and seven grandchildren.

Rafe Banks, Jr.

Gainesville urologist, Rafe Banks, Jr., M.D., died of an apparent heart attack at age 62. He received a biology degree from Emory University and a medical degree from Harvard University in 1943. He was a member of the MAG, the AMA, the Ga. Surgical Society, the Atlanta Urological Society, the Ga. Surgical Congress, a Fellow in the American College of Surgeons, and a Diplomate of the American Board of Urology.

Survivors include his wife, three sons, one daughter, his mother, two sisters, and one grandson.

Victor H. Bennett

At the age of 95, Victor H. Bennett, M.D., Athens, died on November 10, 1981. He had practiced medicine in Gay, GA, for 64 years and had lived in Athens for the past 7 years. He was a graduate of Emory University Medical School.

He is survived by three daughters, three grandchildren, and two great grandchildren.

Morgan Alton Cowan

Macon physician, Morgan A. Cowan, M.D., died at the age of 42 on November 6, 1981. He attended the Medical College of Georgia, and served his internship at the Medical College of South Carolina. He served 1 year as an associate professor of neurosurgery at MCG before joining the Neurological Professional Association. He was certified by the American Board of Neurological Surgery.

Survivors include his wife, one son, one daughter, his mother and father, and one brother.

Stephen M. McDew, Jr.

Stephen M. McDew, Jr., M.D., of Savannah, died November 1, 1981. He was graduated from Hampton Institute and Meharry Medical College.

Born in Georgia, Dr. McDew was past president of the Ga. State Medical Association, a fellow of the American College of Abdominal Surgeons, member of the MAG, AMA, National Medical Association, the Savannah Medical Association, and the Ga. State OB-GYN Society.

He is survived by his wife, two daughters, two granddaughters, and many nieces, nephews, grandnieces, grandnephews, and cousins.

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Adult Psychiatric Program

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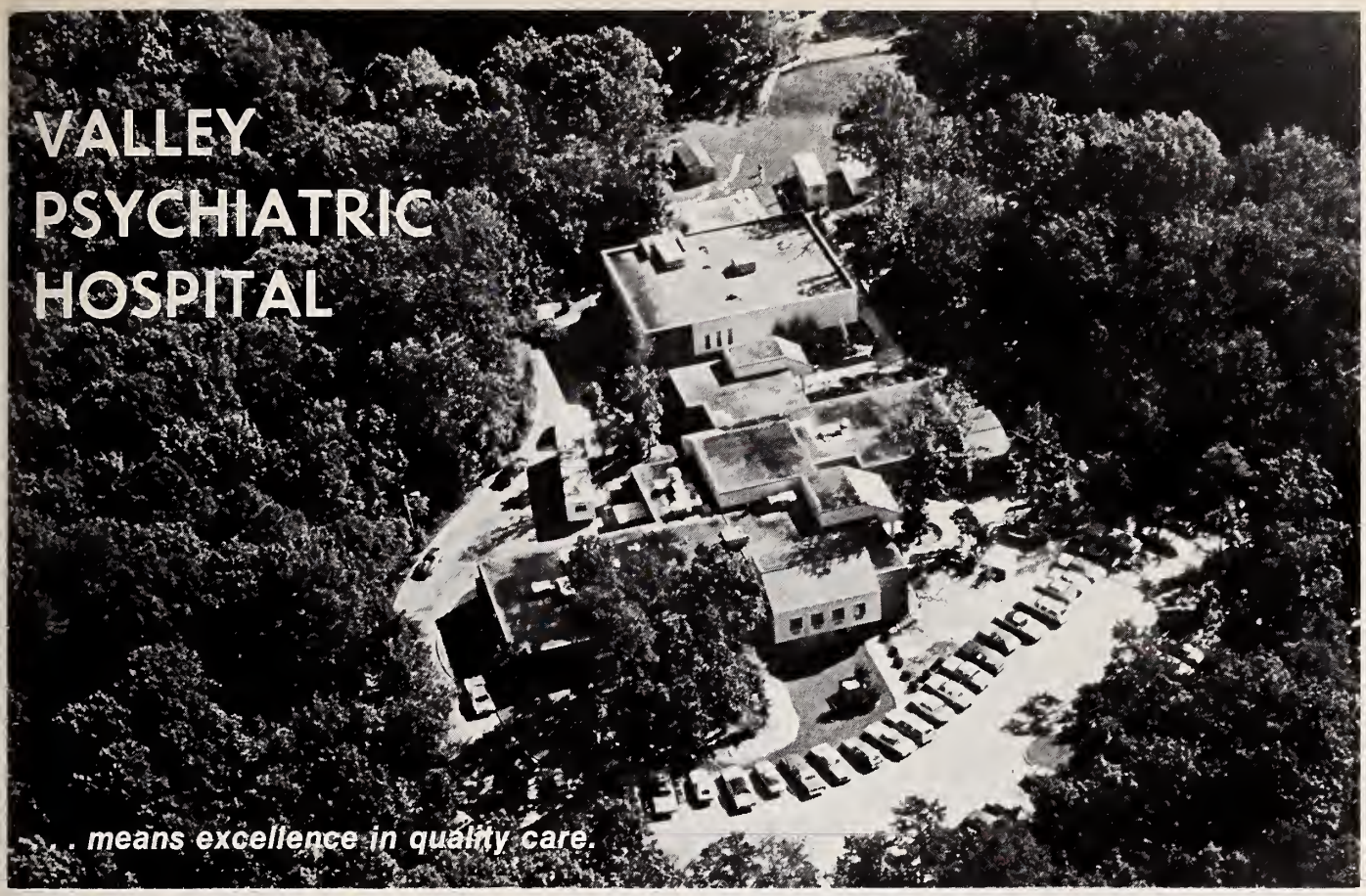
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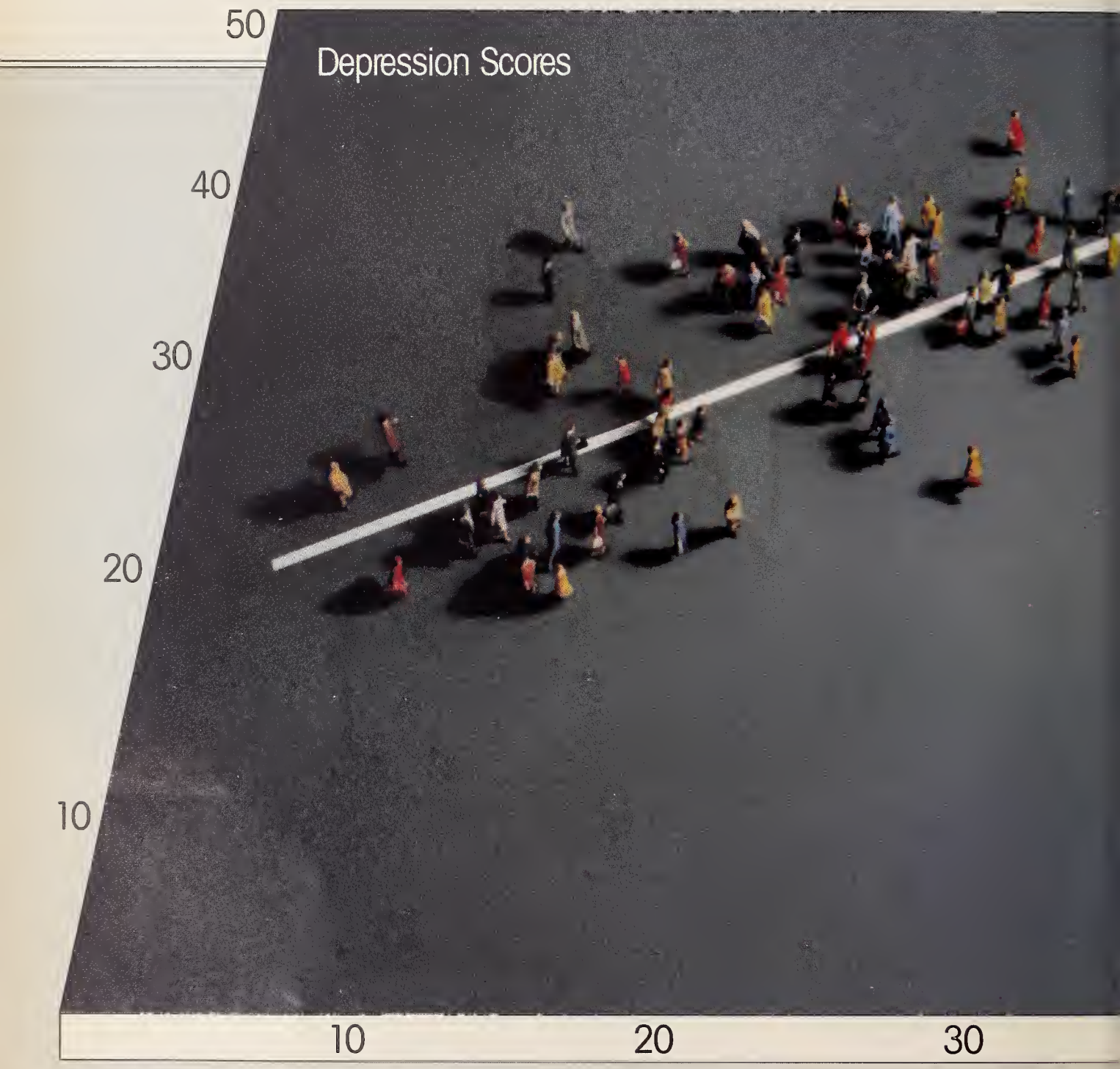
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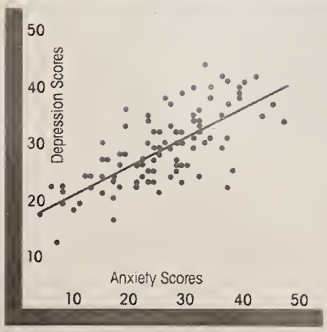
THE COVER

MAG Mutual — probably the Association's most ambitious project — is nearing fruition. Your investment in a Surplus Certificate will insure the benefits associated with a more competitive liability insurance market. Certificates are offered by Prospectus only to Georgia residents. This month's *Journal* features succinct information that will help answer questions you might have. Invest in your future by learning more about MAG Mutual.

Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

FOR THE 7 OF 10 NONPSYCHOTI





Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3]Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE®

EPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]

Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* ed. Jarvik ME. New York, Appleton-Century-Crafts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Claghorn J: The anxiety-depression syndrome. *Psychosomatics 11*:438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlardiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61*:217-225, 1979.

Anxiety Scores

50

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzadiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.
In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

ROCHE®
ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701



Lung cancer is now an equal opportunity tragedy.

Remember when lung cancer was a man's disease. Because men had been smoking longer than women. But the women's smoking boom that started in the 1930's and 40's—is paying most cruel dividends today. Yet most people still think lung cancer is a man's disease. Tell your female patients the true story. That lung cancer is now an equal opportunity tragedy. That's what "you've come a long way, baby" is all about.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office on Smoking and Health
Public Health Service Rockville, MD 28057

Letters to the Editor . . .

Positive Endorsement of *Journal* Article and Letter to Editor — Improving Both Patient Care and Doctor-Nurse Relationships

Dear Sir:

In reference to the article ["Windowless Pain"] written by Dr. James B. Craig in the December, 1981, issue of the *Journal,* I heartily endorse his comments about the increasing prevalence of lack of concern on the part of the attending physician relevant to taking the time to talk to his patients in a reassuring and friendly manner. By taking this short time, he/she is dramatically uplifting the patient's emotional spirits, so vital in the recovery phase of the illness. Somewhere along the line of stereotyped medicine and procedure, this vital instrument is sadly lacking among many physicians in the U.S.A.

Also, I agree with the [Letter to the Editor in the December *Journal*] written by Mary E. Conway, Dean and Professor of the School of Nursing, Medical College of Georgia, who states: "The sooner physicians realize that nurses believe the patient or client is their first concern, and that they are accountable to the patients, the sooner the doctor-nurse relationship can become one of greater satisfaction for all concerned."

Sincerely,
Harold B. Carson, M.D.
P.O. Box 315
Union Point, GA 30669

Counterpoint to the Christmas Editorial

Dear Sir:

Paul Kuntz (*JMAG,* December, 1981) speaks of "a way to God through reason above all particular faiths of mankind . . . a universal way." Jesus Christ's own words conflict with Kuntz's analysis: "I am the way, the truth, and the life. No one comes to the Father *except* through me" (John 14:6, NIV). In addition, Kuntz speaks of "one society with one code of laws." Jesus Christ speaks of two societies in Matthew 25:"you who are blessed" (v. 34) and "you who are cursed" (v. 41). Each group has a different destiny: "eternal punishment" and "eternal life" (v. 46).

The issue needs more comprehensive explanation that either Mr. Kuntz or I have presented. Jesus Christ, however, by His own words spoke of His being the only way. On that basis, He is not compatible with other ways. There are only three options. First, He spoke the truth sometimes and lied sometimes. Second, He may have been demented. If these possibilities are correct, all Christians follow and worship either a liar or a lunatic. The third possibility is that He always spoke the truth. In this case, Christians worship and follow Him as Lord, Savior, and God.

Mr. Kuntz is misrepresenting Christ Himself to state that He is one of several ways. A choice must be made between Jesus Christ and any other way. His [Jesus'] own words confront every person with [the necessity of making] that decision.

Sincerely,
Ed Payne, M.D.
Associate Professor
Department of Family Practice
Medical College of Georgia
Augusta, GA 30912

Incidental Intelligence . . .

Facts About Physician-Owned Professional Liability Companies

- **In 1975, commercial carriers abruptly left tens of thousands of physicians without liability insurance coverage.**
- **A total of 45% of American physicians in private practice are covered by 28 physician-owned companies.**
- **These companies have $600 million in premium income and $2 billion in assets.**
- **The $2 billion in assets now controlled by physicians otherwise would have accrued to commercial insurance companies.**
- **Premiums collected in a state remain in that state. This amounts to approximately $25 million per year in Georgia.**
- **After 5½ years of operation, the physician-owned company in Tennessee fully refunded capital contributions made by their physicians. In October of 1981, the company declared a $2.5 million dividend to be applied to 1982 policy renewals.**
- **Physician-owned companies remain viable and well and have notable success in stabilizing premiums in most areas.**
- **Profits in a physician-owned company revert to policyholders in contrast to commercial companies which are committed to providing a return on investment for their stockholders.**

MAG Mutual — What's In It For You?

More than one year ago, almost 2,000 Georgia physicians pledged to support a physician-owned, professional liability insurance company. After much effort and expense by the Association, we have formed a company — MAG Mutual Insurance Company.

Georgia physicians can act with foresight by investing in their own company in case the liability climate deteriorates as it did in other states in the mid-1970s, causing commercial insurers to pull out of many states. *No physician-owned company has pulled out of a state.* If claims and payments increase, policyholders cannot allow the company to stop writing insurance. MAG Mutual also will assure physician input into the professional liability climate in Georgia. Physicians recounted many instances of claims in which they felt little control over the outcome. Rather, control lay in the hands of non-physicians (insurers, attorneys, or the courts). Along with increased physician input comes a means of influencing tort reform and other changes to improve the professional liability climate.

The Association's feasibility study showed that physicians could realize substantial savings in their insurance premiums through the operation of their own company. These savings, occurring over several years of the company's operations, will be passed on directly to the physician policyholder. Company profits and full investment income credit will be earned on behalf of the physicians.

Finally, *MAG Mutual will bring a new competitiveness to Georgia's professional liability insurance market.* Georgia physicians have already benefited from a potentially competitive situation. This should continue since MAG Mutual and the commercial carriers will need to remain competitive by improving services, offering better coverage, and allowing the physicians to share in more of the company's profits.

The 45% of American physicians in private practice

covered by 28 physician-owned companies will be assured of coverage if things get worse. Premiums may go up; but they will have insurance.

Georgia physicians must be committed to establishing this company if they are to reap its benefits. Three million dollars must be raised as soon as possible so the company can begin writing insurance. The Association has spent more than $200,000 in organizing MAG Mutual. Each day of delay in obtaining the $3 million for the initial capitalization is costing the MAG money.

ACT TODAY BY INVESTING IN A SURPLUS CERTIFICATE.

(Charles D. Hollis, Jr., M.D., President-Elect, MAG)

17th Annual Cobb County Symposium



Art Linkletter

The 17th annual Cobb County Medical Society Symposium will be held on April 1-2, 1982, at Kennesaw College and one of the local hotels. The topic will be "Can Free Enterprise Survive?" Speakers will include Dr. Michael H. Mescon, Chairman of the Department of Management at Georgia State University. Dr. Mescon also holds the Chair of Private Enterprise there. James H. Sammons, M.D., Executive Vice President of the AMA, will speak on matters pertaining to private enterprise as it affects the practice of medicine. Dr. Wayne Lord, an expert on the Soviet economy, will speak on "The Soviet Alternative — Can It Survive?" Former U.S. Secretary of State, Mr. Dean Rusk, is scheduled to speak on "Free Enterprise — The International View." The closing dinner speaker on April 2 will be Mr. Art Linkletter, well-known author and television personality, whose topic will be, "Free Enterprise — The Personal View."

The Cobb County Symposium, which was begun 17 years ago by the Cobb County Medical Society, is now the result of the joint efforts of Kennesaw College, the Auxiliary to the Cobb County Medical Society, the Cobb County Bar Association, the Cobb County Ministerial Association, the Cobb County Dental Society, the Cobb County Pharmaceutical Association, and the Cobb-Marietta Junior League. The main thrust of Symposium '82 will be to explore in detail various factors influencing free enterprise as it involves the private practice of medicine, business, the economy, etc. For further information, write Cobb Symposium '82, Kennesaw College, Marietta, GA 30061, or phone 404/422-8770, ext. 222.

Erratum

In Dr. Alan S. Fleischer's paper, "Microsurgical Cerebral Revascularization: The Extracranial-Intracranial Bypass for Stroke Prevention," in the January, 1982, issue of the *Journal,* please note the following correction: Under **Results** on page 42, the number of the percent in the last sentence of the first paragraph, left column, is printed incorrectly as 6%. The corrected sentence should read: *The overall incidence of infarction in patients followed from 1974 through 1981 was 4%, . . .*

In addition, Reference number 12 was omitted from the list of references on page 42. It is: Sampson D, Boone S. Extracranial-intracranial (EC-IC) arterial bypass: Past performance and current concepts. Neurosurg 1978; 3:79-86.

MEDICAL MEETING CALENDAR

FEBRUARY

21-24—*Hilton Head, SC:* **Diagnosis and Management of Disorders of Bone and Mineral Metabolism.** Category 1 credit. Contact Norman Bell, M.D., Med. Univ. of S.C., Coll. of Med., 171 Ashley Ave., Charleston, SC 29403. PH:803/577-5011 x 350.

22-27—*Augusta:* **17th Annual Family Practice Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Gerald Chambers, Ph.D., Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

25-27—*Gainesville, FL:* **9th Annual Selected Topics in Urology.** Category 1 credit. Contact Univ. of Fl., College of Med. — CME, Box J233, JHM Health Ctr., Gainesville, FL 32610. PH:904/392-3143.

26-27—*Atlanta:* **Georgia's Commitment to Maternal and Infant Health.** Category 1 credit. Contact Phyllis Schwartz, Ga. Council on Maternal and Infant Health, 618 Ponce de Leon Ave., NE, Atlanta, GA 30365-2101. PH:404/894-4241.

27-28—*Augusta:* **Anesthesiology and Acute Medicine — Annual Meeting of the Georgia Society & South Carolina Society of Anesthesiologists.** Category 1 credit. Contact C. F. Johnson, Jr., M.D., Dept. of Anesth., MCG, Augusta 30912. PH:404/828-3871.

MARCH

2-5—*Durango, CO:* **5th Annual Symposium on Emergency Medicine — Trauma.** Category 1 and AAFP prescribed credit. Contact Gerald Chambers, Ph.D., Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18—*Dalton:* **Genetics Inservice for Physicians and Health Professionals.** Category 1 credit. Contact Mae Johnson, RN, DHR Northwest Health District, Suite AA, 111 Bryant's Crossing, Dalton. PH:404/272-2342.

18-20—*Gainesville, FL:* **13th Annual Topics in Internal Medicine.** Category 1 credit. Contact Univ. of Fl. College of Med., Box J233, JHM Health Ctr., Gainesville, FL 32610. PH:904/392-3143.

19—*Columbus:* **Carcinoma of the Breast, Ovary, and Endometrium.** Category 1 credit. Contact Shirley Preston, Amer. Cancer Society, 1422 W. Peachtree St., Atlanta 30309. PH:404/892-0026.

19-20—*Charleston, SC:* **16th Annual Ophthalmology Conference.** Category 1 credit. Contact Mary Lynn West, Med. Univ. of S.C., 171 Ashley Ave., Charleston, SC 29403. PH:803/792-2492.

24-26—*Atlanta:* **Current Concepts in Pediatric Ophthalmology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

26-27—*Callaway Gardens:* **Geriatric Conference for Primary Care Physicians.** Category 1 credit. Contact Michael Sims, M.D., Dept. of Fam. Pract., P.O. Box 7216, Columbus 31908-7216. PH:404/571-1133.

APRIL

1—*Savannah:* **AMA "Giving Your Practice A Check-Up" Seminar for Physicians.** Contact CaRita Connor, Georgia Med. Society, P.O. Box 1703, Savannah 31401. PH:912/355-6607.

2—*Atlanta:* **AMA "Gearing Up for Retirement" Seminar for Physicians.** Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224.

1-3—*Atlanta:* **Emory Medical Alumni Conference.** Contact Alumni Office, Emory Univ., Atlanta 30322. PH:404/329-6199.

2-4—*Atlanta:* **Second Annual Atlanta Eye Congress.** Category 1 credit. Contact Ms. Ginger Lineberger, 3280 Howell Mill Rd., NW, Ste. 207, Atlanta 30327. PH:404/351-2713.

5-7—*Atlanta:* **Pediatrics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Atlanta:* **"Starting Your Practice" Seminar for Residents.** Co-sponsored by AMA & MAG. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/292-0224.

15-17—*Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

17-18—*Atlanta:* **Hemodynamic Monitoring.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

20-24—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-24—*Atlanta:* **Arrhythmias and Cardiac Ischemia: Diagnosis and Management.** Category 1 and AAFP prescribed credit. Contact International Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO, 80112. PH:800/525-8651.

24-25—*Augusta:* **Disease Prevention and Health Maintenance.** Category 1 and AAFP prescribed credit. Contact Gerald Chambers, Ph.D., Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

25-29—*Atlanta:* **31st Annual Scientific Session — Amer. College of Cardiology.** Contact Meeting Services Dept., ACC, 9111 Old Georgetown Rd., Bethesda, MD 20814. PH:301/897-5400.

MAY

3-8—*Augusta:* **17th Annual Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

13-14—*Atlanta:* **Fifth Annual Course on Management of the Chronic Renal Disease Patient.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322 PH:404/329-5696.

13-15—*Atlanta:* **Annual Update in Pathology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

17-19—*Atlanta:* **Coronary Disease — 1982.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-21—*Atlanta:* **Eighth Annual Course on Techniques in Orthopaedic Surgery: Deformities of the Spine.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

20-21—*Callaway Gardens:* **10th Annual Perinatal Medicine Conference.** Category 1 credit and AAFP prescribed credit. Contact Micki Souma, M.D., Chief, Dept. OB/GYN, Med. Ctr., P.O. Box 951, Columbus 31902. PH:404/324-4711.

21-22—*Atlanta:* **Update of Systemic Lupus Erythematosus.** Category 1 credit. Contact Karen Crenshaw, West Paces Ferry Hospital, 3200 Howell Mill Rd., Atlanta 30327. PH:404/351-0351, x 208.

JOURNAL
of the medical association of
georgia

The 128th Annual Session of the Medical Association of Georgia

Welcome to Savannah!

The Georgia Medical Society, the Auxiliary to the Georgia Medical Society, and your host city Savannah are honored to extend an official invitation to the 1982 Annual Session of the Medical Association of Georgia's House of Delegates. Preparations are under way to offer to our guests a diversity of facilities ranging from a uniquely contemporary setting for the deliberations of MAG officials and delegates to a panorama of entertainment and recreation in gracious, elegant, historic Savannah. For our first-time visitors and frequent returnees, the grand old lady of the colony, River City, is something special! Our efforts are dedicated to assuring you a successful meeting and to making your visit a memorable event. WELCOME!

Sincerely,
Eloise B. Sherman, M.D.
President, Georgia Medical Society

On April 22, 1982, the Medical Association of Georgia's (MAG's) House of Delegates will convene at 8:00 p.m. in the Regency Ballroom at the Regency Hyatt in Savannah. The House of Delegates will be preceded by a General Session of MAG members at 7:00 p.m.

This Annual Session will confine itself to the business affairs of the Association. By House of Delegates action in 1973, the scientific portion of the meeting was separated from the business portion and is held in November of each year.

Hotal Reservations

The Regency Hyatt is the headquarters for this meeting. All MAG delegates, alternate delegates, and officers will be receiving hotel reservation cards from MAG Headquarters. All others must make reservations directly with the hotel. The address is: Two West Bay Street, P.O. Box 1467, Savannah, GA 31402.

Registration

Registration facilities will be maintained in the foyer outside the Regency Ballroom for delegates, alternate delegates, directors, and all members. Registration hours will be as follows:

Thursday, April 22 . . . 3:00 p.m.-7:00 p.m.
Friday, April 23 7:30 a.m.-12:00 noon
Saturday, April 24 8:30 a.m.-5:00 p.m.
Sunday, April 25 7:00 a.m.-12:00 noon

Message Center

The Auxiliary to the MAG will maintain a message desk in the foyer of the Regency Ballroom for the convenience of the membership. The messages will be posted on a bulletin board at the message desk in the foyer.

General Sessions

The opening General Session will be called to order by MAG's president, L. Newton Turk, III,

M.D., on Thursday, April 22, at 7:00 p.m. in the Regency Ballroom. Featured at this opening ceremony will be the report of the President of the Auxiliary to MAG.

There will be no General Session on Saturday.

The Second General Session will be held following adjournment of the House of Delegates on Sunday, April 25. At this time, the newly-elected officers will be installed.

House of Delegates

The first session of the House of Delegates will convene on Thursday, April 22, at 8:00 p.m. in the Regency Ballroom. Nominations for MAG officers will be made, and reports of officers and committees will be presented. Resolutions and other new business will be placed before the House. Reference Committees will be appointed, and all resolutions and reports will be referred by the Speaker to the appropriate Reference Committees.

The second session of the House of Delegates will convene at 10:00 a.m. on Saturday, April 24, in the Regency Ballroom. Reference Committees will report to the House at this time.

The third and final session of the House of Delegates will convene at 9:00 a.m. on Sunday, April 25, at which time the results of the election of officers will be announced and the remaining Reference Committee reports will be presented.

Reference Committees

According to the Bylaws of the Association, all resolutions and reports which contain recommendations must be referred to Reference Committees for open hearings. All members are invited and encouraged to appear before the Reference Committees to express their views. The Committees will open their hearings on Friday, April 23, at 9:00 a.m.

Election of Officers

Nominations for the officers of the Association will be made at the first session of the House of Delegates on Thursday, April 22. The election will take place before the House of Delegates on Sunday, April 25. Delegates will be certified by members of the Credentials Committee and receive their ballots at that time. Voting will be done in appropriate voting booths. After the polls close at 9:00 a.m., the Tellers Committee will count the ballots, and the results will be announced at the General Session following the adjournment of the House of Delegates. If it is necessary to have a run-off election, it will be held during the House meeting.

President's Reception

The MAG will honor its president at a reception to be held at 7:00 p.m., Saturday, April 24.

Alumni Events

Receptions and dinners sponsored by the various medical school alumni organizations are often held during the Annual Session. Notice will be made prior to the Annual Session.

GaMPAC

GaMPAC functions are to be announced.

Officers of the Association 1981-1982

Office Held		Term Ending
*PRESIDENT	L. Newton Turk, III, Atlanta	1982
*PRESIDENT-ELECT	Charles D. Hollis, Jr., Albany	1982
*IMMEDIATE PAST PRESIDENT	H. Hilt Hammett, Jr., LaGrange	1982
PAST PRESIDENT	Earnest C. Atkins, Atlanta	1983
PAST PRESIDENT	Carson B. Burgstiner, Savannah	1982
*FIRST VICE PRESIDENT	William C. Collins, Atlanta	1982
*SECOND VICE PRESIDENT	Virgil W. McEver, Jr., Warner Robins	1982
*CHAIRMAN OF THE BOARD OF DIRECTORS	Jack A. Raines, Columbus	1982
*SECRETARY	William D. Logan, Jr., Atlanta	1984
*TREASURER	James H. Sullivan, Columbus	1984
*SPEAKER OF THE HOUSE	Jack F. Menendez, Macon	1983
*VICE SPEAKER OF THE HOUSE	James A. Kaufmann, Atlanta	1983
VICE CHAIRMAN, BOARD OF DIRECTORS	Joe L. Nettles, Savannah	1982
EDITOR, *JMAG* (EX-OFFICIO MEMBER OF BOARD)	Edgar Woody, Jr., Atlanta	1982

* (Denotes Executive Committee)

Directors and Alternate Directors

District	Directors	Alternate Directors	Term Ending
1	Leon E. Curry, Metter	Douglas O. Cope, Statesboro	1982
2	Sammie Dixon, Tifton	Lannie Copeland, Moultrie	1982
3	V. W. McEver, Jr., Warner Robins	L. Kenneth Raynor, Warner Robins	1982
6	James M. Skinner, Griffin	Norman P. Gardner, Thomaston	1983
7	Richard A. Griffin, Cartersville	Bannester L. Harbin, Jr., Rome	1983
8	Joe C. Stubbs, Valdosta		1983
9	Rupert H. Bramblett, Cumming	C. Peter Lampros, Toccoa	1984
10	M. A. Hubert, Athens	William M. Headley, Milledgeville	1982
Bibb County Medical Society			
	Beverly B. Sanders, Macon	Charles A. Lanford, Macon	1984
Cobb County Medical Society			
	Charles R. Underwood, Marietta	Dan B. Stephens, Marietta	1984
DeKalb Medical Society			
	H. Duane Blair, Decatur	Charles McDowell, Decatur	1984
Dougherty County Medical Society			
	J. Dan Bateman, Albany	Frank F. Middleton, III, Albany	1983
Floyd-Polk-Chattooga Medical Society			
	John I. Dickinson, Rome	Robert A. Farrell, Rome	1984
Hall County Medical Society			
	Henry Jennings, Jr., Gainesville	John Reed, Gainesville	1983
Medical Association of Atlanta			
	William C. Collins, Atlanta	Bob G. Lanier, Atlanta	1983
	T. J. Anderson, Jr., Atlanta	W. Ben Spearman, Atlanta	1984
	J. Harold Harrison, Atlanta	William C. Waters, III, Atlanta	1982
Georgia Medical Society			
	Joe L. Nettles, Savannah	Clyde L. Olson, Savannah	1982
Muscogee County Medical Society			
	Jack A. Raines, Columbus	E. M. Molnar, Columbus	1983
Richmond County Medical Society			
	Ronald F. Galloway, Augusta	Luther M. Thomas, Jr., Augusta	1984

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the active achievement of anyone who in the judgement of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies, and all nominations must be accompanied by supporting biographic data and received at MAG Headquarters no later than March 1. If no nominations and supporting data are received, no award will be made. No nominations for this award will be accepted from the floor. If given, this award will be presented on Thursday, April 22. By custom, this award usually has gone to a Georgia physician; however, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at MAG Headquarters no later than March 1. They must be accompanied by biographic data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Thursday, April 22.

Civic Endeavor Award

This award, presented for the first time at the 1969

Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at MAG Headquarters no later than March 1. The recipient of this award will be selected by a three-man secret committee which will determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made on Thursday, April 22.

Family Physician of the Year

This award is presented to an outstanding family physician in Georgia. Presentation of the award is made at the Annual Session. The president of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award on Thursday, April 22. Deadline for receiving nominations for this award was January 16, 1982.

Component County Society Representation to the 1982 MAG House of Delegates

(1981 CMS Member Count for 1982 Delegates to Annual Session)

County Medical Society	Number of Delegates
Altamaha	1
Baldwin	2
Barrow	1
Bartow	1
Ben Hill-Irwin	1
Bibb	11
Blue Ridge	1
Burke	1
Camden-Charlton	1
Carroll-Haralson	2
Cherokee-Pickens	1
Clayton-Fayette	4
Cobb	11
Coffee	1
Colquitt	1
Coweta	1
Crawford W. Long	4
Decatur-Seminole	1
DeKalb	14
Dougherty	5
Douglas	1
Elbert	1
Emanuel	1
Flint	1
Floyd-Polk-Chattooga	5
Franklin	1
Georgia Medical Society	10
Glynn	3
Gordon	1
Gwinnett-Forsyth	2
Habersham	1
Hall	5
Hart	1
Jackson-Banks	1
Laurens	2
Lumpkin	1
McDuffie	0
Medical Association of Atlanta	51
Meriwether-Harris-Talbot	1
Mitchell	1
Muscogee	10
Newton-Rockdale	1
Oconee Valley	1
Ocmulgee	1
Ogeechee River	2
Peach Belt	3
Randolph-Stewart-Terrell	1
Richmond	16
Screven	1
South Georgia	3
Southeast Georgia	1
Southwest Georgia	1
Spalding	2
Stephens-Rabun	2
Sumter	1
St. John's Parish	1
Thomas Area	3
Tift	2
Troup	3
Upson	1
Walker-Catoosa-Dade	2
Walton	1
Ware	3
Washington	1
Wayne	1
Whitfield-Murray	3
Wilkes	1
Worth	1

Official Program

(All functions of the House of Delegates will be held in Regency Hyatt-Savannah)

Thursday, April 22

4:00 to 7:00 Registration of Delegates and Other Session Attendees
Location: Foyer

7:00 General Session
Location: Regency Ballroom
Presiding: L. Newton Turk, III, M.D., President
Opening Ceremonies
Report of the President of the Auxiliary to the Medical Association of Georgia, Mrs. Perry M. White of Atlanta
Presentation of Association Awards
Family Physician of the Year
Hardman Cup
Civic Endeavor Award
Distinguished Service Award
Announcements
Recess

8:00 to 10:00 House of Delegates, First Session
Location: Regency Ballroom
Presiding: Jack F. Menendez, Speaker, and James A. Kaufmann, Vice Speaker
Presentation, Correction and Adoption of the Minutes of the 1981 House of Delegates
Appointment of Convention Committees
Nominations for Association Officers and AMA Delegates
Reports of Officers and Committees
Introduction of New Business
Announcements
Recess

Friday, April 23

7:30 Registration
Location: Foyer
9:00 Reference Committee Hearings

Saturday, April 24

8:30 Registration
Location: Foyer
10:00 House of Delegates, Second Session
Location: Regency Ballroom
7:00 President's Reception

Sunday, April 25

7:00 Registration
Location: Foyer
7:00 to 9:00 Polls Open for Election of Association Officers and AMA Delegates
Location: Foyer
9:00 House of Delegates, Third and Final Session
Location: Regency Ballroom
Presiding: Jack F. Menendez, Speaker, and James A. Kaufmann, Vice Speaker
Invocation
Reports of Reference Committees
Announcements
Announcements of Election Results
Adjournment of House of Delegates
12:00 General Session, Final
Location: Regency Ballroom
Presiding: L. Newton Turk, III, M.D., President
Installation of Officers
Adjournment of 128th Annual Session

AMA Delegates and Alternate Delegates, Jan. 1, 1982

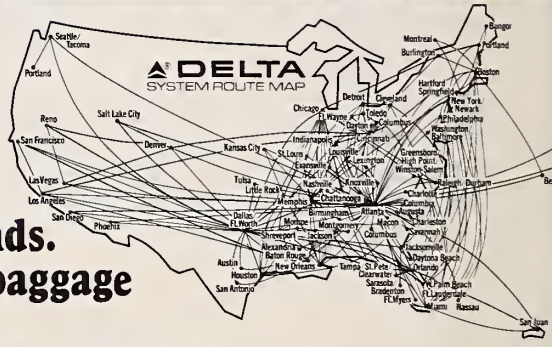
Delegates	Term Ending
C. Emory Bohler, Brooklet	12/31/83
F. William Dowda, Atlanta	12/31/83
Harrison L. Rogers, Jr., Atlanta	12/31/82
J. Dan Bateman, Albany	12/31/82
H. Hilt Hammett, Jr., LaGrange	12/31/83

Alternate Delegates	Term Ending
Carson B. Burgstiner, Savannah	12/31/83
Charles D. Hollis, Jr., Albany,	12/31/83
Joe C. Stubbs, Valdosta	12/31/82
William W. Moore, Atlanta	12/31/82
S. William Clark, Jr., Waycross	12/31/83



Delta is an air line run by more than 36,000 professionals. Like Rudy Wilson, Passenger Service Agent.

Rudy has been with Delta for 12 years. As a "red coat," he can cut through red tape in seconds. To help you with everything from ticketing to baggage to flight connections.



Chances are, you'll never need a Passenger Service Agent like Rudy. But when you do, you'll recognize him right away. He'll be the one with the warm smile, helpful hand and bright red jacket. All tailored to make sure your Delta flight runs as smoothly as possible. He's a Delta professional.

Delta is ready when you are.®



This is Delta's Wide-Ride™ Lockheed L-1011 TriStar with cabins 8 feet high and 19 feet wide. You fly in quiet luxury.


BEWARE
THE
WINTER
WEATHER!

RU-TUSS

Dispel the Clouds of Fall and

RU-TUSS®
TABLETS

Each prolonged action tablet contains: Phenylephrine Hydrochloride 25 mg • Phenylpropanolamine Hydrochloride 50 mg • Chlorpheniramine Maleate 8 mg • Hyoscyamine Sulfate 0.19 mg • Atropine Sulfate 0.04 • Scopolamine Hydrobromide 0.01 mg • Each Ru-Tuss tablet acts continuously for 10 to 12 hours.

Symptomatic Relief of Sneezing and Nasal Congestion

Comprehensive decongesting, antihistaminic and anti-secretory reliever for patients with nasal, sinus and other upper respiratory irritation.

• Eases breathing • Reduces sneezing
• Reduces tearing • Dries the drip

One tablet b.i.d. gives round-the-clock relief to adults and older children (12 years and over).



ELIEVERS

Winter Respiratory Discomfort

RU-TUSS®
EXPECTORANT

Each fluid ounce contains: Codeine Phosphate 65.8 mg • (WARNING: MAY BE HABIT FORMING) Phenylephrine Hydrochloride 30 mg • Phenylpropanolamine Hydrochloride 20 mg • Pheniramine Maleate 20 mg • Pyrilamine Maleate 20 mg • Ammonium Chloride 200 mg • Alcohol 5%

Symptomatic Relief of Coughing with Nasal and Bronchial Decongestion

Full range symptom-reliever for patients with air way congestion in the upper chest as well as the nose and throat.
• Blocks the cough • Loosens mucus
• Reduces sneezing • Eases breathing
• Tasty, so it's easy to take



To Relieve the Symptoms of Winter Weather Upper Respiratory Distress

RU-TUSS®/RU-TUSS®

TABLETS EXPECTORANT

RU-TUSS®

Tablets

DESCRIPTION

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoardination, visual disturbances, mydriasis, xeratamia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insamnia. Large overdoses may cause tachypnea, delirium, fever, sfupor, coma and respiratary failure.

DOSAGE AND ADMINISTRATION Adults and children aver 12 years of age, ane tablet marning and evening. Nat recammended for children under 12 years af age. Tablets are ta be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets	NDC 0524-0058-01
Battles af 500 Tablets	NDC 0524-0058-05

Federal law prohibits dispensing without prescriptian.

DISTRIBUTED BY:
Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

MANUFACTURED BY:
Vitarine Company, Inc.
Springfield Gardens, New York 11413

RU-TUSS®

Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 m
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 m
Phenylpropanolamine Hydrochloride	20 m
Pheniramine Maleate	20 m
Pyrilamine Maleate	20 m
Ammonium Chloride	200 m
Alcohol	5

Ru-Tuss Expectorant is an oral antifussive, antihistaminic, nasal decangestant and expe torant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upp respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhir tis. Also, for the temporary relief of symptoms associated with hay fever allergies, nas congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an an hypertensive or antidepressant drug containing a monoamine oxidase inhibitor contraindicated

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma ar in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient shou be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant m cause drowsiness. Patients should be warned of the possible additive effect caused l taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle operating dangerous machinery (See Warnings). Caution should be taken with patier having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddine dryness of mucous membranes, tightness of the chest, thickening of bronchial secretio urinary frequency and dysuria, palpitation, tachycardia, hypotension, hypertension, fai ness, dizziness, tinnifus, headache, incoordination, visual disfurbances, mydriasis, xer stomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric c tress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessne excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and ev convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoonfuls in c 24-hour periad. Children 2 to 6 years af age: ½ teaspaanful every 4 hours, not exceed 3 teaspaanfuls in any 24-haur period. Children under 2 years af age: Use directed by a physician.

HOW SUPPLIED: (16 fl. oz.)

Pint Bottles	NDC 0524-1010-

Federal law prohibits dispensing without prescriptian.

MANUFACTURED AND DISTRIBUTED BY:
Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106
Pioneers in medicine for the family

Auxiliary to the Medical Association of Georgia

57th Annual Meeting

April 22-23, 1982

Hyatt Regency Hotel
Savannah, Georgia

President's Invitation



April 22-24, 1982, is the date for the 57th Annual Meeting of the Auxiliary to the Medical Association of Georgia. The new Hyatt Regency Hotel in beautiful Savannah is the place. All this will contribute to making this convention the best ever.

Dr. Beverley Mead, Associate Dean, Creighton Medical School, Omaha, Nebraska, will speak. His topic will be "Getting It All Together in Marriage."

Dr. Stuart Briscoe, a Presbyterian minister, Brookfield, Wisconsin, will be the dinner speaker. His topic will be "The Total Person in Marriage."

Saturday morning there will be a special "Savannah tour" for your pleasure.

Join other Auxiliary members to learn, contribute, and fellowship while we are in Savannah.

Mrs. Perry M. White
President, A-MAG

Welcome to Savannah



It gives me great pleasure to welcome you to the 57th Annual Convention of the Auxiliary to the Medical Association of Georgia.

The Auxiliary to the Georgia Medical Society (Savannah) is here to make your stay in our "Historical City" an enjoyable one. We are happy to cohost this convention with members of our neighboring Wayne and Ware County Auxiliaries. Savannah has many attractions — the riverfront, the historical homes and buildings, as well as its famous eating establishments — to name a few. I hope you will find your stay a pleasant one, and if any questions or problems arise, please feel free to contact any of us for help.

Again, welcome to Savannah!

Mrs. Dent W. Purcell
Convention Chairman

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general sessions of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making and seconding the motion.
7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
8. All persons appearing on the program must be seated near the platform when the session opens.

Convention Program

1981-82 Theme: Project a Positive Profile: Mentally, Physically, and Spiritually

THURSDAY, APRIL 22, 1982

8:30 to 5:00 **Hospitality, Registration, and Information**
Room: Prefunction "C"

8:30 to 5:00 **Exhibits**
Room "C"

10:00 to 11:30 **Pre-Convention Executive Board Meeting**
Room "D-E"

12:00 **Luncheon** — Auxiliary and Guests
Room "F"
Speaker: Mrs. Mylie E. Durham, Jr. (Pat), AMAA Director

1:30 **House of Delegates**
First General Session
Room "D-E"

5:30 to 6:30 **Reception**
Widow's Walk

7:00 **MAG House of Delegates**
Auxiliary Report
AMA-ERF Check Presentation

8:00 **Dinner**
Trustees Banquet Hall
Speaker: Dr. Stuart Briscoe, Brookfield, Wisconsin
"The Total Person in Marriage"

FRIDAY, APRIL 23, 1982

7:30 to 8:30 **Breakfast** — Auxiliary Members and Guests
The Windows

8:30 to 5:00 **Hospitality, Registration, Information**
Prefunction South

8:30 to 5:00 **Exhibits**
Room C

9:00 to 12:30 **House of Delegates**
Second General Session
Room D & E
Speaker: Beverley T. Mead, M.D., Omaha, Nebraska

1:00 **Luncheon** — Auxiliary Members & Guests
Room A
Post Convention Executive Board Meeting
Room A

1:30 **Past President's Luncheon**
West Brook Room

SATURDAY, APRIL 24, 1982

9:30 to 10:30 **Breakfast**
Widow's Walk

10:45 **Tour of Savannah** (To Be Announced)

7:00 to 9:00 **MAG Reception** (MAG Members and Wives)

A-MAG State Officers — 1981-82

President **Mrs Perry M. White**
1547 Cave Road, N.W., Atlanta 30327
(Medical Association of Atlanta) (404) 261-0880; 233-2251

President-Elect **Mrs. David C. Thibodeaux (Barbara)**
588 Heyward Circle, N.W., Marietta 30064
(Cobb) (404) 422-9233

First Vice-President **Mrs. Arlie R. Mansberger, Jr. (Ellen)**
3128 Walton Way Extension, Augusta 30909
(Richmond) (404) 738-3471

Second Vice-President **Mrs. George R. Jones (Judy)**
1491 Council Bluff Drive, N.E., Atlanta 30345
(DeKalb) (404) 636-9565

Third Vice-President **Mrs. W. Jack Smith (Eldred)**
725 Oglethorpe Avenue, St. Simon's Island 31522
(Glynn) (912) 638-3234

Area Vice Presidents

Northwest **Mrs. Charles J. Rey, Jr. (Margaret)**
3514 Chochise Drive, N.W., Atlanta 30339
(Cobb) (404) 436-7734

Northeast **Mrs. Charles B. Thomas (Pearline)**
335 West Lake Drive, Athens 30806
(Crawford W. Long) (404) 549-1629

Southwest **Mrs. George M. Chastain, III (Sara Anne)**
2350 Winchester Drive, Albany 31707
(Dougherty) (912) 883-3806

Southeast **Mrs. Neal F. Yeomans (Della)**
704 Magnolia Street, Waycross 31501
(Ware) (912) 283-7263

Recording Secretary **Mrs. Charles W. Walden (Grace)**
2875 Cravey Trail, N.E., Atlanta 30345
(DeKalb) (404) 939-5160

Treasurer **Mrs. Maurice G. Patton (Louise)**
822 Windsor Court, Augusta 30909
(Richmond) (404) 738-2342

Corresponding Secretary **Mrs. Thomas W. Marks (Mary Ann)**
1011 W. Paces Ferry Road, N.W., Atlanta 30327
(Medical Association of Atlanta) (404) 261-5994

Historian **Mrs. George W. Galloway (Jean)**
140 River Court Parkway, N.W., Atlanta 30328
(Cobb) (404) 393-3226

Parliamentarian **Mrs. John G. Bates (Glenda)**
Box 329, Cotton Hill Road, Cuthbert 31740
(Randolph-Stewart-Terrell) (912) 732-3050

AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

American Medical Association Auxiliary 1981-1982

President **Mrs. Harry S. Dworsky (Isobel)**
(home address) 2677 Vista Grand Court, San Leandro, California 94577
(415) 483-0801
(AMAA office) 535 North Dearborn Street, Chicago, Illinois 60610
(312) 751-6166

Bylaws Committee Chairman **Mrs. John G. Bates (Glenda)**
Box 329, Cotton Hill Road, Cuthbert, Georgia 31740
(Randolph-Stewart-Terrell) (912) 732-3050

1981-1982 State Committees

Achievement Awards **Mrs. William A. Wolff (Nancy)**
1 Yosemite Court, Columbus 31907
(Muscogee) (404) 563-4042

Address Corrections **Mrs. Charles E. Brown (Lorenna)**
2383 Alton Road, N.W., Atlanta 30305
(Medical Association of Atlanta) (404) 355-4291

Allied Health Careers (See Health Education)

AMA-ERF (American Medical Association — Education & Research Foundation)
..... **Mrs. A. Frank Isels (Fay)**
2103 Chatham Drive, Albany 31707
(Dougherty) (912) 439-9073

Archives **Mrs. Milton F. Bryand (Atchie)**
3569 Dumbarton Road, N.W., Atlanta 30327
(Medical Association of Atlanta) (404) 233-9831

Awards
Awards Coordinator **Mrs. Phil C. Astin, Jr. (Frances)**
100 Remington Circle, Carrollton 30117
(Carroll-Haralson) (404) 834-4318

Mrs. Olin S. Cofer Achievement Award
Chrm. — **Mrs. William A. Wolff (Nancy)** (Muscogee)
Mrs. George R. Jones (Judy) (DeKalb)
Mrs. Charles W. Walden (Grace) (DeKalb)

James M. Brawner, Sr., M.D., Certificate of Excellence
Chrm. — **Mrs. Milton B. Satcher (Ann)** (MAA)
Mrs. Michel A. Glucksman (Irene) (Glynn)
Mrs. George W. Galloway, Jr. (Jean) (Cobb)

Doctor's Day Awards
Chrm. — **Mrs. Russell E. Andrews, Jr. (Betty)** (Floyd-Polk-Chattooga)
Mrs. Michel A. Glucksman (Irene) (Glynn)

Marie S. Burns, Safety Awards
Chrm. — **Mrs. Quentin T. Lawson (Joan)** (South Georgia)
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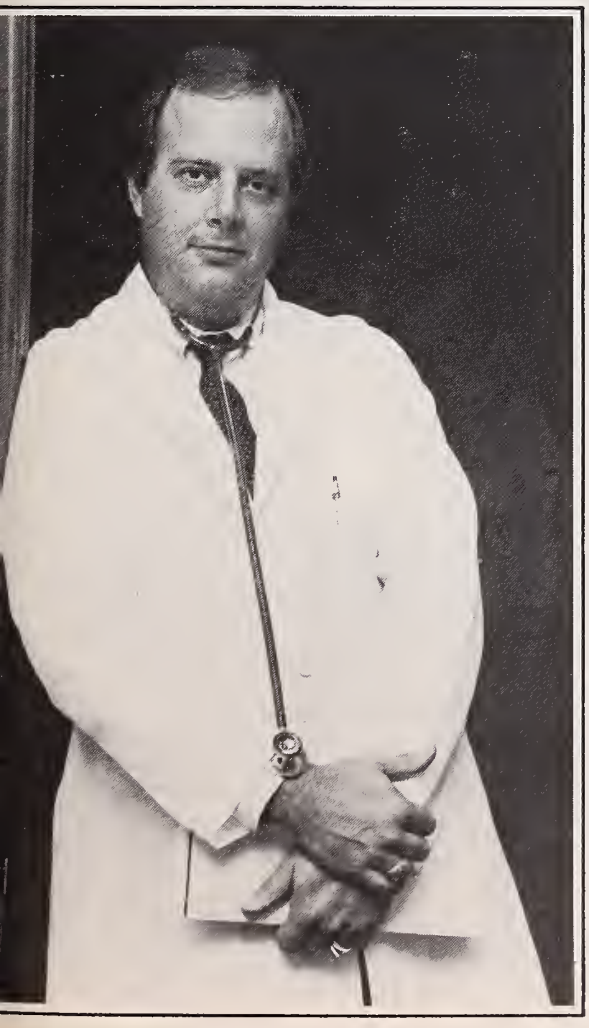
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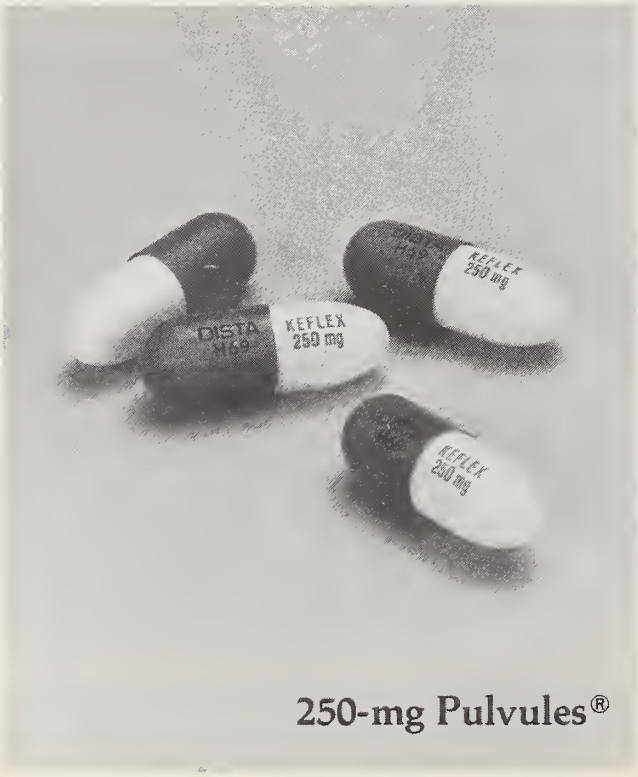
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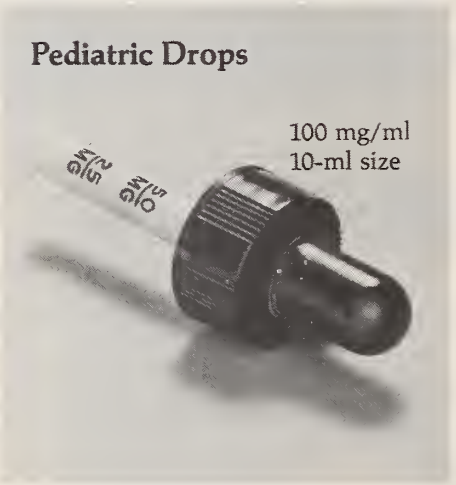


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JOHN A. RUSCA, M.D., and WILLIAM E. HUGER, JR., M.D., *Atlanta***

In the October, 1981, issue of the Journal, *a paper was published concerning a new Head and Neck Medicine and Surgery specialty. The* Journal *has a responsibility to serve as a forum for the expression of differing viewpoints within the Association. The following article is therefore submitted as a position statement by the Georgia Society of Plastic Surgeons, Inc.*

Part I

GEORGIA PLASTIC SURGEONS were amused to see in the October, 1981, issue of the *Journal of the Medical Association of Georgia* Dr. Jack Anderson's partyline article about the otolaryngology fraternity having added Head and Neck Medicine and Surgery to its name. This name change is especially interesting. Dr. Anderson seemed to be a prime mover in forming the American Academy of Facial Plastic Surgery, to claim an aptitude for doing cosmetic surgery. Also, seemingly under his tutelage, but with a plastic surgeon as its President-Elect to give it respectability, the American Association of Cosmetic Surgeons has been formed. This latter organization has graciously volunteered to act as a peer review group for cosmetic surgery. Both organizations, which appear to be splinter groups of the otolaryngology fraternity, are relatively unknown and appear blissfully devoid of any particular formal qualifications. Is there now a Head and Neck Medicine and Surgery Section of the Council and Academy of Otolaryngology or can just anyone in the fraternity do cosmetic surgery? After all, under Georgia law, a fresh graduate of an accredited medical school after 1 year of internship may begin practice as a neurosurgeon, ophthalmologist, or whatever. Why not a cosmetic surgeon? In our own legislative stupidity, however, let us not misinterpret the meaning of a name change, which carries with it no more credential than just that alone.

In recent years, the specialty of plastic surgery, which has traditionally included a wide range of cosmetic procedures, has become very attractive to various practitioners who wish to generate a lucrative cosmetic practice, but perhaps understandably do not wish to encumber themselves with the years of postgraduate surgical training required for plastic surgery certification. Although not feeling that training is necessarily the mother of competence, these practitioners obviously would agree that necessity is the mother of invention. If one's qualifications are shaky, the best conceivable smoke screen is to create a new organization with a high-sounding name, join it, issue yourself a certificate for display in your waiting room, and circulate the good news to all the medical societies in the country via a mass mailing! Admittedly, announcing that your organization is now set up for peer review is a stroke of presumptuous genius, which must be admired by even the most aggressive cosmetic-surgeon-without-portfolio.

This name game is becoming an old one, but the faces of the players are strangely familiar. This publicity emanates from a group of otolaryngologists who seem to be unhappy with their image and are trying desperately to do something about it. A new Academy, a new Association, and now a new name

* From Gilbert and Sullivan's "Mikado."

** Dr. Rusca is Immediate Past President, and Dr. Huger is Past President, of the Georgia Society of Plastic Surgeons. Dr. Rusca's address is 5675 Peachtree — Dunwoody Rd., NE, Ste. 506-C, Atlanta, GA 30342. Dr. Huger's address is 35 Collier Rd., Ste. 675, Atlanta, GA 30309.

change! My, my, the potential for future word combinations is positively underwhelming!

Georgia plastic surgeons who have gone the route of long years of required training have no quarrel with men in other specialties who wish to do cosmetic surgery, provided they are adequately trained in these procedures before applying for the necessary hospital privileges. We do feel strongly, however, that they should at least identify themselves properly, as do other members of the various surgical subspecialties.

The current president of the American Association of Cosmetic Surgeons is Walter E. Berman, M.D. The 1981 Directory of Medical Specialists lists him as an otolaryngologist, practicing in Beverly Hills, without listing any formal training for him in plastic and reconstructive surgery. The President-Elect is Dr. Richard A. Grossman, who is indeed a plastic surgeon, practicing in Sherman Oaks, California. The organization must be desperate for respectability so that necessity demands his selection. Nevertheless, one pint of whipping cream cannot significantly enrich thousands of gallons of skim milk.

Part II

In 1917, ophthalmologists, attempting to upgrade their profession, founded the American Board of Ophthalmology as a certifying agency only. It was without legal power, but it established acceptable levels of background training and competence in order to regulate its specialty and protect the public. Recognizing the importance of a certifying agency, the otorhinolaryngologists, to their credit, followed suit in 1924. This trend toward measured competence continued until the last of 23 boards, the American Board of Emergency Medicine, was established in 1979. Recognizing the trend early, the American Board of Medical Specialties was established in 1933, and along with the AMA Council of Medical Education, has carefully guided the incorporation and approval of specialty boards to establish and maintain excellence and competence in each specialty.

The American College of Surgeons, originally set up as an examining board, was primarily interested in basic standards, so that not until 1937 was the American Board of Surgery re-established to evaluate background training and competence in general surgery. Prior to that time, plastic surgery, which developed from the reconstruction of World War I veteran injuries beginning in 1917, was an integral part of general surgery, with a strong core curriculum in general surgery. At that time, with the establishment of the American Board of Surgery for general surgery, the American Board of Plastic Surgery was born as a subsidiary of the American Board of Surgery and was so recognized in May, 1938. It was granted major specialty status in May, 1941. Throughout its development, the American Board of Plastic Surgery recognized that, although the specialty developed from every other specialty, a strong core curriculum in general surgery and a close bond with the American Board of Surgery were essential to ensure superior competence in the management of plastic surgery patients. That recognition was foremost in the minds of those who established the American Society of Plastic and Reconstructive Surgeons in 1931, as well as in those who established the American Society of Aesthetic Plastic Surgery in 1968. That recognition has not changed. Some other specialty boards have not adhered to that course of planned excellence in training.

The American Board of Medical Specialists has not recognized the American Board of Cosmetic Surgery as a valid specialty board signifying adequate additional training.

The bona fide plastic surgeon must have 3 years of training in general surgery as his core curriculum, and a minimum of 2 years of training in an approved plastic surgery residency, per se, to include reconstruction of both congenital and acquired defects aimed at improvement in both functional and aesthetic elements. With this background, excellence in the aesthetic element is built into his training, and the necessity for its inclusion over a minimum 2-year period has been proven without question in the opinion of parent certifying agencies.

Among those specialties not required by its board to have a strong core curriculum in general surgery has been otolaryngology, in spite of the early foresight of its ancestors in becoming the second specialty to form an agency to establish standards of competence. Somewhere along the way, care of the whole patient was seemingly diverted toward care of only the patient's ears, nose, and throat. No internship was required. Only 1 year of surgical residency and 3 years of otolaryngology training became required. Then came antibiotics and many diseases of the specialty were successfully treated without surgery. What should they do? Aesthetic surgery of the head and neck seemed the obvious field to invade.

Several years ago, a small group of otolaryngologists, seemingly wanting to improve their image, formed the American Academy of Facial Plastic and Reconstructive Surgery claiming excellence in all cosmetic facial procedures. Requirements for membership did not, and still does not, include adequate additional training in cosmetic procedures not en-

joyed by other otolaryngologists. In the past year, that group has distributed to hospital administrations in this country a brochure entitled, "Delineation of Hospital Privileges for the Practice of Head and Neck Plastic Surgery." In it, statements from the American Medical Association, the American Board of Medical Specialists, the American College of Surgeons, the Joint Commission for Accreditation of Hospitals, and the American Society of Internal Medicine are printed out of context to support their claim that the system of certification by specialty boards is meaningless and is invalid to establish competency. As a result, the American Society of Plastic and Reconstructive Surgeons has been forced to distribute its answer entitled, "Plastic Surgery and Its Practitioners," which points out the necessity of establishing a measure of competence in order to protect the public from horrendous surgical errors based on incompetence by virtue of professed adequate training not actually experienced.

The American College of Surgeons has not recognized the otolaryngology name change to "Head and Neck Medicine and Surgery" as signifying adequate additional training.

But the effect of this ill conceived threat by a small group of men has been felt. The otolaryngologists have been pressured into adding a fifth year of training. It is an elective year sandwiched in just before the senior resident year and not required as a year of head and neck or cosmetic surgical training. Also, the otolaryngologists have been forced to express a name change to include head and neck medicine and surgery. The same small group set up the American Board of Cosmetic Surgeons. But has anything really changed? The answer is an emphatic no! The American College of Surgeons has not recognized the name change as signifying adequate additional training. The American Board of Medical Specialists has not recognized the American Board of Cosmetic Surgery as a valid specialty board signifying adequate additional training. Instead "mini-training" is being used by the otolaryngologists. As recent as October, 1981, Dr. Jack Anderson, under the sponsorship of the "American Foundation for the Medicine and Surgery of Appearance" scheduled a 5-day seminar, the written objective of which was "to provide the surgeon who has a special interest in cosmetic facial surgery, regardless of his basic background, with practical information about the area of practice and to demonstrate proven methods currently being used." Further stated was that "attendance makes one eligible for later participation in the mini-residency program of the American Foundation for the Medicine and Surgery of Appearance." Is this how competent plastic surgeons are trained — by short seminars and mini-residencies?

We must not let a maverick group, representing a quasi-national organization, interfere with local responsibility, that of dictating the credentials for hospital privileges.

The position of the bona fide plastic surgeons of Georgia is very clear and concise. They have no desire to prevent properly trained surgeons, otolaryngologists or otherwise, from practicing their specialty, including plastic and reconstructive surgery. What is being asked is that they subject themselves to the same training, credentialing, and peer review as do all other plastic surgeons. The American College of Surgeons and the American Board of Medical Specialists ask no more than that either.

The American Board of Plastic Surgery is currently "bending over backwards" to cooperate in a trial program. The background training of diplomates of the American Board of Otolaryngology is currently considered adequate for them to enter 2-year accredited plastic surgery training programs leading to American Board of Plastic Surgery examination. The Plastic Surgeons of Georgia welcome among us such graduates credentialed by the American College of Surgeons and the American Board of Medical Specialists through the medium of the American Board of Plastic Surgery. There are many, many very fine, well trained, properly motivated, and highly respected otolaryngologists who provide excellent patient care. We must not let a maverick group, representing a quasi-national organization, interfere with local responsibility, that of dictating the credentials for hospital privileges. We should heed the American College of Surgeons, the American Board of Medical Specialists, and particularly the Joint Commission of Accreditation of Hospitals whose Accreditation Manual clearly states that "eligibility as defined by the appropriate board, is an excellent benchmark to use as a basis for privileged delineation" in protecting the public interest.

We hope that all of the physicians and people of Georgia will not be mislead by a name change and will join us in urging our otolaryngology colleagues who have an interest in cosmetic surgery to acquire the established minimum 2-years' training in an accredited plastic surgery residency before presenting themselves to their colleagues and the public as competent cosmetic surgeons.

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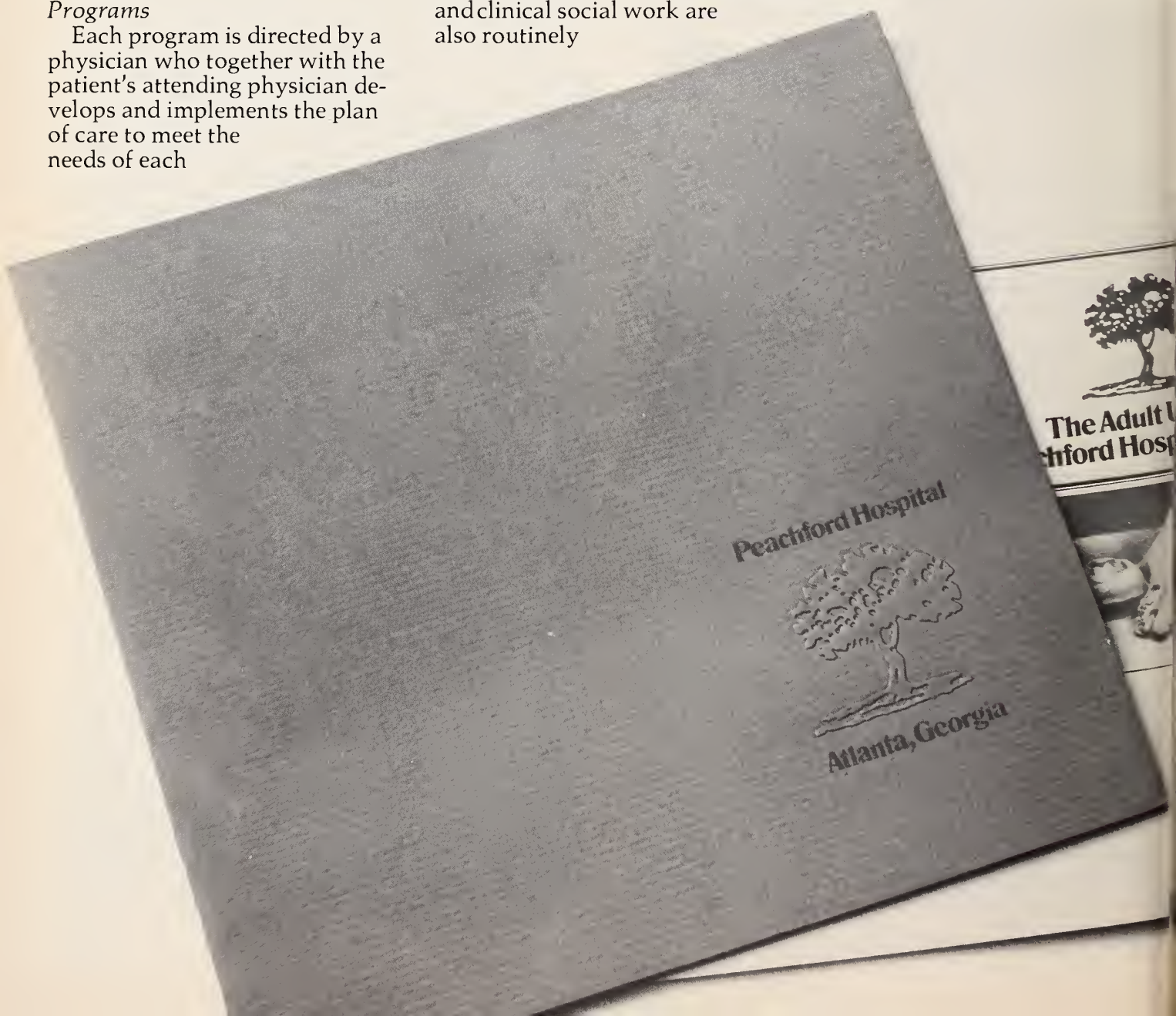
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rious problems.

rovides individualized services for hildren between the ages of 4 and 2. The structured daily program or all children includes individual nd group therapy sessions, as well s individualized programs for edu- ation, activities therapy, develop- ental play, and social services. rt, dance, music, occupational, nd recreation therapy are vital omponents of the program. arents are involved in family sessions and parents' groups.

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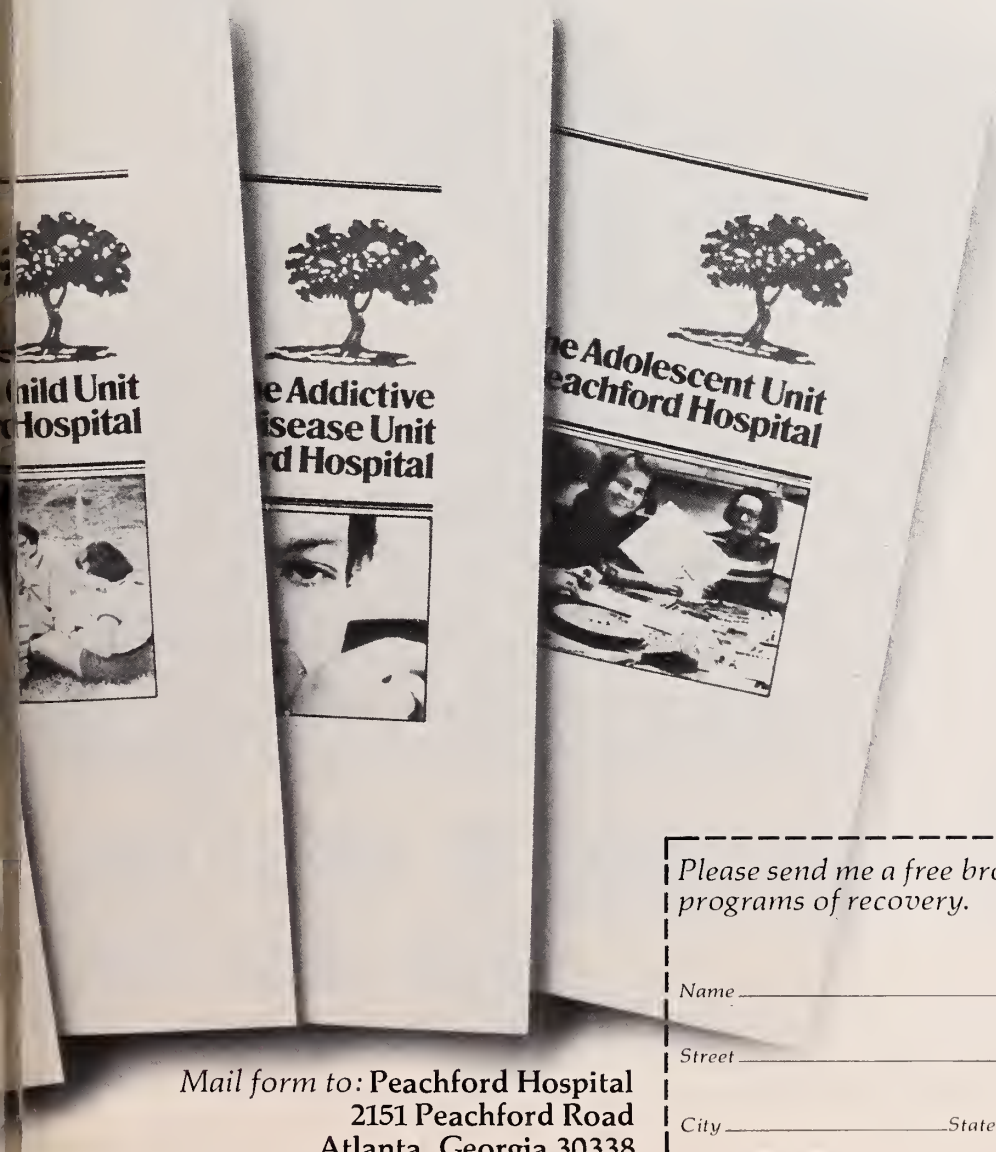
The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

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A position statement by the Georgia Thoracic Society regarding the definition of and compensation for byssinosis.

Byssinosis

GARNETT J. GIESLER, JR., M.D., *LaGrange**

This position paper was developed by the Clinical Practice Committee of the Georgia Thoracic Society at the request of the Society's Executive Committee. It represents the official position of the Georgia Thoracic Society regarding the definition of and compensation for byssinosis.

The Georgia Thoracic Society has sensed a need to develop a position paper on byssinosis for several years. This need has become more apparent recently with the increased interest of certain public organizations to pursue compensation for this disease in all workers in the cotton/textile industry with any degree of pulmonary dysfunction, regardless of other risk factors being involved. We feel obliged to be supportive of those patients who have legitimate and unequivocal pulmonary injury related to their employment in the textile industry. We also feel obliged to provide our lay organization, the Georgia Lung Association, with some specific recommendations for its field representatives in dealing with these issues.

Background

Relatively early in the 19th century, an investigator named Kay[1] described a respiratory disease that affected primarily cotton workers. He correctly attributed the symptoms to excessive cotton dust exposure. Because of the onset of chest tightness and fever on Monday morning, it became known as the "Monday Morning Fever" or "Monday Morning Syndrome." The condition has been described in cotton, flax, and hemp workers and has subsequently been called byssinosis, a term derived from a Greek word meaning linen or fine flax. It has been reported in countries throughout the world where cotton, flax, and hemp are spun or processed. Much of the early clinical investigation on byssinosis was assumed to be peculiar to certain areas in Britain, since most investigative work was carried out in these areas. Over the past several decades, however, it has also been reported from Spain, Egypt, the United States, the Netherlands, Sweden, and many other countries.

Clinical Features

The onset of byssinosis is characterized by chest tightness in the cotton worker as he returns to work on Monday morning. Most persons have worked in the cotton or textile industry for more than 10 years before they have onset of these symptoms. Similar symptoms may occur even after the person returns to work after a holiday, so they are not confined to Monday morning. Initially, the symptoms are limited to the first day after the employee returns to work, but they gradually occur throughout the week after a long latent period. The patient then has onset of a productive cough and shortness of breath. He may later be compelled to stop work as the latter becomes more acute. At this time, the employee generally has a chronic cough productive of mucoid or mucopurulent sputum. Clinically, the end stage is indistinguishable from that of chronic bronchitis and severe idiopathic asthma.

The acute, reversible effects of exposure to cotton dust (i.e., the Monday morning chest tightness) can be reproduced in healthy subjects by an inhalation challenge with cotton dust or with an aqueous extract of it and also with cotton bract. Not all mill workers react to these challenges, however, and this has allowed the development of a testing system which identifies both reactors and non-reactors.

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The early symptoms of byssinosis are reversible, but eventually permanent, irreversible airways obstruction persists. The detection of the disease in its early stages depends largely on a history of the Monday morning chest tightness and on the demonstration of a reduction in ventilatory capacity between the beginning and the end of the first shift back to work.

A grading system has evolved based on the Medical Research Council Questionnaire as follows:

Grade ½ — Occasional chest tightness on Monday or on the day on which work is resumed.

Grade 1 — Chest tightness and/or difficulty in breathing on Monday or on the day on which work is resumed.

Grade 2 — Chest tightness and difficulty in breathing, not only on Monday, but on other days of the week also.

Smoking introduces extraneous influences into this classification, and the questionnaire is most reliable in non-smokers.

The diagnosis of byssinosis is based on the following factors:

1) History consistent with "Monday Morning Syndrome";
2) Employment in a high-risk area in the mill for a number of years;
3) Demonstration of pulmonary dysfunction in the form of chronic airways obstruction.

Pulmonary Function Abnormalities

The ventilatory capacities of cotton, flax, and hemp workers have been repeatedly demonstrated to be lower than those of comparable controls. The decreased ventilatory capacity is found almost entirely in workers in certain areas of the mill, particularly in the opening and card rooms and less frequently in the spinning and weaving rooms. Furthermore, it is possible by means of challenge studies to pick out "reactors." It has been postulated that by excluding such reactors from the carding room, this would greatly decrease the frequency of byssinosis.

The characteristic feature of byssinosis is the reduction of ventilatory capacity following the mill worker's return to work. This affect is characteristically seen on Monday morning or the first day back at work, and such measurements of FEV_1 and serial measurements of FEV_1 will show a significant decline from morning to evening. The decrement that occurs on Monday morning is nearly always greater than that which is seen later in the week and may represent as much as .5 to 1 liter. Smoking does not appear to significantly affect a relative decline on Monday morning in FEV_1.

In the established byssinotic with persistent shortness of breath, the Monday morning changes in ventilatory capacity may be minimal or absent. These subjects must be regarded as having irreversible obstruction, and even when removed from further exposure to cotton dust, no significant improvement is likely to be demonstrated.

Pathology

There are very few descriptions in the literature of pathologic changes definitely associated with byssinosis. A recent study[2] indicates that exposure to cotton dust leads to mucus gland hyperplasia in large bronchi, but does not lead to emphysema. Thus, the pathologic changes in byssinosis indicate it is a disease of the airways. This would explain the drop in FEV_1.

Etiology

Theories to explain the airway changes which are noted are included in the literature, but none appears to be totally satisfactory or explanatory of the trends noted. The agent responsible for broncho-constriction is located in the cotton bract. Byssinosis is very distinct from the syndrome of immunological asthma seen in youth, but may be quite similar to the idiopathic asthma seen in adults. There does appear to be some relationship of changes in ventilation that occur after the inhalation of cotton dust and the release of histamine, and this has been noted from human lung tissue in vitro. Other researchers have favored an immunologic basis for byssinosis and have suggested that it is secondary to an endotoxin-like substance in textile dust. Others have proposed that it is much like a Type 3 or Arthus reaction.

Georgia Thoracic Society Position

According to the Georgia Code Annotated (1979), the disease process known as byssinosis is not listed specifically as a compensable disease (Chapter 114-8). Even though this disease occurs in a relatively small number of textile workers, it is a process peculiar to those workers, particularly those in high-risk areas within the industry.

Any legislative action dealing with this issue, however, needs to be done with particular care and with strong input from chest physicians and occupational health physicians dealing most closely and directly with this problem.

The difficulty from the medical viewpoint is that neither an accurate diagnostic description of the disease nor its pathologic confirmation is well defined. With the addition of smoking in the lifestyle of the patient, it becomes extremely difficult to separate out those components of an illness which may be related to cotton dust exposure and those related to ancillary factors, such as smoking, etc.

Statistically, as supported by the literature, byssinosis is a relatively infrequent disease among textile workers. Chronic bronchitis, emphysema, and lung cancer among textile workers remain the most common lung diseases.

It is neither reasonable nor sound to make all respiratory diseases occurring in the textile mill compensable from an occupational standpoint. Most of these severe non-occupational lung diseases can qualify for disability under Social Security if they meet certain criteria.

The major difficulty in this entire issue pivots around two key points: (1) defining the signs and symptoms of byssinosis; and (2) determining the percentage of disability resulting from work-related causes, as opposed to non-work related causes using some established criteria.

Regarding compensation for byssinosis, we would like to clarify those points which we support and those which we oppose and to state emphatically our continued concern as pulmonary specialists for the safety and health of all citizens of Georgia, including those involved in the textile industry:

We support:

(1) Continued efforts to improve the working place in the textile industry for all employees;
(2) The addition of byssinosis to the list of compensable diseases in the Georgia Code, as it is appropriately defined;
(3) Improvement in the compensation process, such that payments for compensation can be made more expeditiously to deserving employees;
(4) Continued efforts to define more specifically this diagnosis, even in the presence of cigarette smoking;
(5) Continued efforts to establish standard medical criteria for determining the percentage of disability resulting from work-related causes.

We Oppose:

(1) Classifying all respiratory illnesses in textile employees as byssinosis.

Recommendations to the Georgia Lung Association

Realizing our commitment as a medical branch of the Georgia Lung Association, the Georgia Thoracic Society views its responsibility as one of advising administrative officials and staff members as to their response to requests from various lay organizations and associations in obtaining aid for byssinosis patients:

Specifically, we recommend:

(1) That the Georgia Lung Association continue its established goals of providing educational materials to *all* citizens in areas dealing with smoking, chronic airways obstruction, occupational lung disease, and others;
(2) That the Georgia Lung Association not affiliate themselves officially or unofficially with any organization seeking to provide workman's compensation — i.e., the Georgia Lung Association's primary mission is one of providing educational and research support;
(3) That the Georgia Lung Association continue its present efforts in attempting to help industry and employees establish sound smoking cessation/education programs.

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WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

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Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

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Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

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The authors outline a process for delineating the pathologic functioning of low self-esteem feelings in burn patients and correcting for this functioning.

Losses as Stimuli to Psychic and Behavioral Dysfunction in Burn Patients — A Treatment Rationale and Approach

E. LAWRENCE COOK, M.D., JOSEPH M. STILL, JR., M.D., and PATRICIA N. WATKINS, M.D., *Augusta**

BURN PATIENTS often exhibit emotional, cognitive, and behavioral problems during their hospitalization, treatment, and rehabilitation. Emotional problems frequently seen include depression, anxiety, and hostility. Cognitive problems include delusions and hallucinations. Behavioral problems usually take the form of lack of cooperation with planned treatment or rehabilitative efforts or even outright refusal of these interventions.

Sometimes emotional, cognitive, and behavioral problems are the result of mental illness known to have existed before the thermal injury. In other cases, these symptoms can be explained by organic factors resulting from the injury or subsequent treatment, such as electrolyte imbalance or adverse reactions to anesthetic or sedative medication.

Common, however, is the case of the patient whose emotional, cognitive, and behavioral states before thermal injury seemed normal and whose current organic status seems insufficient to explain the emergence of these subsequent problems. These patients appear to have acquired mental dysfunction as a result of the thermal injury. Their depression, anxiety, hostility, confused thinking, or behavioral dysfunction is unexpected and seems excessive and inexplicable in view of their acceptable adjustment before thermal injury.

Closer investigation, however, reveals that in these cases the losses sustained as a result of thermal injury act as a trigger [or stimulus] to activate dormant mental dysfunction. This activation leads to the development of emotional, cognitive, or behavioral symptoms, or some combination of these.

Our experience reveals that when losses act as stimuli, the losses are real. We invariably find that the patient has in fact lost something, even when the extent of his injury or resulting disability appears minimal.

Losses that act as stimuli can be clinically categorized into two types: 1) reality losses, and 2) losses of compensatory techniques.

Reality Losses

Burn patients have suddenly and at least temporarily lost some degree of health, appearance, and/or functional capability as a result of the thermal injury.

In the process of coming to terms with these losses, the patient may exhibit emotional, cognitive, or behavioral symptoms. In dealing with only these reality losses, the patient does not experience any lowering of self-esteem. Thus understood, his symptoms can then be characterized as reactive (or "normal") depression, anxiety, hostility, thought confu-

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sion, or as a behavioral expression of these. This type of mental dysfunction is analagous to normal grief in that it occurs in response to one or more external losses and is not the result of an internal loss or lack of self-confidence or self-esteem.[1]

In patients sustaining only reality losses, depression is by far the most common symptomatic presentation. It is also usually present in an underlying fashion with any of the other symptoms.[2]

Symptoms due to reality losses tend to resolve spontaneously as the patient comes to terms with his reality losses. This resolution occurs over time as the patient sequentially grieves, accepts his losses, and begins to adapt to functioning in his environment with an altered appearance and new limitations within physical, vocational, and interpersonal arenas.

Our approach to speeding this natural recovery follows a three-step sequence:

1) We accept the patient's symptom and do not ask him to change it initially. This is the most important of all the steps that we take;
2) Through conversation, we develop the patient's understanding of the symptom as the result of his reality losses;
3) We assist the patient in accepting that his symptom is the legitimate consequence of his reality losses by telling him that his symptom is an understandable, and even reasonable, result of his reality losses.

Additional maneuvers that reinforce this sequence include having other staff members and the patient's family acknowledge and discuss the patient's reality losses with him and verbalize their acceptance of his right to feel hurt or depressed. Discussion of these initial maneuvers with staff and family members helps them learn an alternative way of relating to the patient during his recovery period which can be of assistance to the patient and less stressful to themselves.

It is not the low self-esteem which is pathologic, but the functioning of the low self-esteem to produce symptoms.

Our experience is that this sequence and additional maneuvers, rather than prolonging the patient's depression or reinforcing his undesirable behavior, tends to shorten the time required for the underlying "normal" depression to resolve and the resultant undesirable behavior to remit.

Even prior to full resolution of symptoms occurring, the patient is usually able to change his behavior or to suspend disruptive behavior in response to requests from staff members who have followed this approach in their dealings with the patient. This occurs because the legitimacy of the patient's communication about his losses has been accepted by these staff members and, because of their assistance, the losses are being actively accepted and put into perspective by the patient.

At this point, it is far easier for the patient to accept directives in regard to his treatment or rehabilitation because acceptance of the losses forms the basis for the establishment of hope that adaptation to the losses can occur. This establishment of hope motivates the patient to cooperate in treatment and rehabilitation as he begins to perceive these measures as helpful to him in learning to adapt and continue to function on some level despite his losses.

Losses of Compensatory Techniques

Low self-esteem (culturally referred to as an "inferiority complex") can be found to one degree or another in most people. There is hardly anyone who at some time in his life has not wondered whether in some or in many ways he might not be as good or as worthwhile as others, or might not be capable of functioning to meet needs which would sustain and perpetuate life.

In individuals in whom these worries are particularly severe or pervasive, various behavior patterns evolve which function in an attempt to decrease the resultant chronic psychic discomfort. These behavioral patterns are therefore referred to as compensatory patterns or techniques, i.e., compensating intrapsychically for feelings of worthlessness[3, 4] or about helplessness,[4, 5] the most common low self-esteem feelings verbalized by patients.

In burn patients who have a pattern of using that which was lost in the thermal injury [i.e., health, appearance, functional capability] to compensate for low self-esteem feelings, the loss leaves these feelings uncompensated. The low self-esteem feelings of worthlessness or about helplessness then produce acute psychic pain. At this point, new emotional, cognitive or behavioral patterns are implemented in an attempt to reduce the acute psychic pain by defending against, compensating for, or expressing the low self-esteem feelings. When these new patterns impair the patient's coming to terms with his losses, they are then recognized as seemingly new emotional, cognitive, or behavioral problems.

In summary, in these cases:

1) The former attribute or function was previously used as a compensatory technique to compensate for low self-esteem feelings;
2) The loss of the former attribute or function leads to activation of feelings of worthlessness or feelings about helplessness which are acutely intrapsychically painful;

3) The mind responds by expressing the pain or by attempting to decrease the intrapsychic discomfort through the elaboration and adoption of new defensive or compensatory patterns. Unfortunately, these new patterns may also function to prevent the patient's maximal cooperation with planned treatment interventions.

Our process of delineation of the loss of a compensatory technique and of therapy for the underlying pathologically functioning low self-esteem is as follows:

1) To find what the patient has lost, i.e., *exactly* what it meant to the patient, first explore and develop what the patient had through conversations with the patient. In a society dominated by the work ethic, most commonly what the patient had was the ability to work and to achieve a role of being a good, moral, hard worker and/or a good wife and mother. Other compensatory techniques commonly encountered depend upon the presence of previous good appearance, previous opportunity or even such basic issues as the patient's former hope that he would continue to live and possibly overcome errors he made in past coping.
2) Confront the patient with the fact that he has truly lost that which he formerly had (thus establishing and partially legitimizing the loss).
3) Ask the patient how he feels about himself as a person within the context of the loss of his particular attribute or function (Ex: "How do you feel about yourself as a person now that you can no longer work on the job you had?"). If no low self-esteem is derived from this maneuver, the patient should be handled as outlined for reality losses (above).
4) When low self-esteem feelings are reported by the patient, explore these through further conversation with the patient focusing on specific expressions of opinions or of feelings about the self. It is important to note the patient's own verbalizations for these feelings, as his own choice of descriptive terms may provide useful clues to the more precise nature and etiology of his particular type of low self-esteem feelings. For example, we commonly hear statements of opinions or of feelings about the self such as "I feel worthless" or "I feel useless" (active low self-esteem feeling of worthlessness). Common also are "I can't do what I used to do" or "I just feel lost" (active low self-esteem feeling about helplessness).
5) Once the precise nature of the patient's low self-esteem feelings is known, a sequence of interventions is begun to deactivate these feelings. To begin the deactivation process, imply a cause and effect sequence of events[4] (Ex: "What has happened to you in the past, even before the injury, that you would feel this way about yourself?"). If the patient doesn't know, ask what he thinks or feels might have been contributory. This maneuver provides a way of getting around the situation where the patient feels he must have the complete answer before he can offer any opinion. At this point the examiner may find:

A. An incident or a related sequence of events in the developmental experience, as a result of which the patient drew the conclusion that he was worth less than others about him, or was helpless to deal with domination and control by others, or felt lost and did not know which way to turn. Originally, the incident or series of incidents may have been assessed via immature cognitive mechanisms which would lead the patient to draw the conclusion that something was wrong with him or that he could not deal adequately with everyday demands.[4] By re-examining the original sequence of events in this manner, the patient is given the opportunity to utilize more mature cognitive mechanisms of assessment, and thus is often able to realize for the first time both how his original conclusions were drawn (the legitimacy of those conclusions in their original context) and the probable fallacy of their continued application to current life situations.

 In order for this realization to occur, when an incident is remembered it is important that the patient be lead to find alternative, non self-blaming reasons why the parents or important others treated him as they did in terms of a logical cause and effect sequence of events. Common examples would be that there may have been a very strict parent or an illness (such as alcoholism) in one of the parents, causing the patient to be deprived of interpersonal input or to be otherwise imposed upon. Often, significant benefit may be derived from carrying this cause and effect sequence of reasoning back even further. For instance, one may find that the patient's parent, in turn, may have had strict or overbearing parents who were not warm or were too constraining, thus preventing the patient's parent from learning appropriate parenting techniques for use during the patient's developmental experience.

B. No remembered incident, but remembered teachings of the parents or of the culture. Many children are taught to defer their interests to the interests of others, or are taught

not to resist the assertiveness of others, i.e., some children learn that others are more important, and some learn that saying no to demands and requests is wrong; still others are told that they will be abandoned if behavior does not meet an apparently arbitrary parental standard.

C. No remembered incidents from the developmental experience or from the teachings of the parents or culture. When this is the case, the patient may have identified with the low self-esteem feelings of an important person, usually a parent. In this case, it is critical that the patient understand what happened to the parent that would cause the parent to be as he was when the patient as a child copied the parent's personality (identification).

6) At this point, the patient frequently realizes and states that his low self-esteem feelings are legitimate in terms of the cause and effect sequence of events that produced them, but we do not leave this to chance. If he does not spontaneously verbalize this realization after the cause and effect sequence of events has been elaborated, we tell him that he should have whatever constitutes his opinion or feeling about himself. This maneuver neutralizes or deactivates the patient's low self-esteem feelings. Once these feelings are deactivated, there is no longer any motivation to maintain the new, possibly dysfunctional emotional, cognitive, or behavioral patterns.

A pitfall to avoid is rejection of the patient's communication about his low self-esteem feelings. To attempt to remove the low self-esteem or to induce high self-esteem would be an erroneous focus for the therapy. It is not the low self-esteem which is pathologic, but the functioning of the low self-esteem to produce symptoms. Deactivation of this functioning without attempted eradication of the low self-esteem feelings themselves is therefore the more productive therapeutic strategy.

Summary

Burn patients have been subjected to sudden injury and losses. Emotional, cognitive, and behavioral symptoms in burn patients can be due to exacerbation of previous mental illness, organic causes, reality losses of health, appearance or functional capability, or losses of compensatory techniques for dealing with early-learned feelings of low self-esteem. Patients who formerly used their good health, appearance, or functional capability as techniques of compensating for previously ingrained low self-esteem can no longer compensate for the low self-esteem feelings when these attributes, assets, or functional capabilities are lost. The low self-esteem feelings are thus activated with resultant emotional, cognitive, or behavioral symptom production. We outline a process for delineating the pathologic functioning of low self-esteem feelings and correcting for this functioning.[6]

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Credit

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Why MAG Mutual?

The Medical Association of Georgia's continuing campaign to make the professional liability insurance market more stable and secure for all Georgia physicians has repeatedly emphasized the benefits of a physician-owned insurance company such as MAG Mutual.

Apparently, however, we have not said it often enough or forcefully enough to a sufficient number of Georgia physicians. MAG Mutual will indeed be a stabilizing force in the professional liability insurance market in Georgia. It will give policyholders control of their future insurance coverage that will help *all* physicians by introducing effective competition in the marketplace — and it will do much more.

Since MAG Mutual will issue a claims made policy,* no "tail coverage" *need be purchased from your present insurance carrier in order to change to MAG Mutual.

MAG Mutual will give physicians a new source of strength in negotiating for tort reform through the legislature and the court system in Georgia. Physicians in neighboring states are benefiting from this organized strength. For example, in 1975, Indiana ended up with no insurance coverage. Since then, its physicians have started their own company which has achieved an effective program of legislative tort reform. This tort reform includes: a 2 year statute of limitations from the time of occurrence of an incident, not from the time of discovery of an incident; a mandatory screening panel to adjudicate professional liability insurance claims; and a cap of $100,000 on any malpractice claim payment from the insurance company. In addition, the Indiana company established a trust fund where amounts

Your immediate investment in a Surplus Certificate is needed to raise the initial capitalization essential to begin writing insurance.

up to an additional $400,000 could be paid in a case if approved by the court. Since 1975, there have been 23 claims made in the State of Indiana in which $100,000 or more has been paid. Indiana physicians have stabilized the professional liability climate in that state, and there has been little, if any, increase in the number of claims or in the amount of their cost.

Indiana's story as well as those from many other states were recounted at a recent Forum on Medical Affairs held at the Interim Meeting of the American Medical Association House of Delegates in December. Physician-owned companies, writ-

By introducing effective competition in the marketplace, MAG Mutual will indeed be a stabilizing force in the professional liability insurance market in Georgia.

ing $600 million in annual premiums and with assets of over $2 billion, emphasized repeatedly the benefits of a physician-owned company.

In New York the average cost of a claim has increased from $20,000 in 1978 to $100,000 in 1982. Because of this increase in the cost of claims, premium charges have of necessity increased. This does *not* mean, however, that the physician-owned company in New York is having difficulties beyond those of dealing with increased costs. The company in New York is definitely viable and serving well the physicians in that state.

The Medical Association of Georgia is committed to the success of MAG Mutual, and your support plays a key role. Your immediate investment in a Surplus Certificate is needed to raise the initial capitalization essential to begin writing insurance. *You* know the benefits inherent in the success of MAG Mutual, but they cannot be realized until you participate with your investment in the Company.

The issue right now is *not* whether to change insurance carriers. The issue is whether to support your medical association's formation of a company that can effectively compete with the other carrier in Georgia which currently has approximately 95% of the professional liability insurance market in the state. You can benefit financially from this competition no matter from whom you buy your insurance. Of course, in the long run, I believe you can realize a greater financial gain by insuring with a physician-owned liability company.

Charles D. Hollis, Jr., M.D.
President-Elect, MAG

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4. The company, an offspring of the MAG, will be an ally and partner, strengthening and increasing the effectiveness of organized medicine throughout the state.

5. The resources of the company will be available to effect meaningful legislative tort reform. Indiana is a prime example.

6. Continuing educational activities can be supported and perhaps rewarded through premium credits.

7. Effective risk management programs will be fostered, teaching physicians to avoid the trauma of malpractice claims.

8. Surplus Certificates are transferable debt instruments and can be given to a charity or a family member.

Charles D. Hollis, Jr., M.D.

Hard Drugs?

Its use permeates all strata of society; its abuse is flagrant; it is grown in the fields of Turkey, the fields of south Georgia, and other areas scattered throughout the world. The product for street use is prepared by curing the leaves of plants of the deadly nightshade family *(Solanaceae)* and then wrapping, rolling, cutting, or mincing them in various ways. It is smoked, chewed, sniffed, and dipped by often unwary victims. Its active ingredients include central nervous system depressants, vascular constrictors, chemical irritants, and carcinogens. It is directly responsible for hundreds of thousands of deaths in this country each year. Its economic toll is measured in billions of dollars each year. Its personal, medical, social, and emotional toll is immeasurable.

These statements could be made with minor variations about most of the hard drugs used and abused illegally in this country. Here, however, we are referring to tobacco. The major differences between it and other drugs is that it is grown and used legally; its use is socially acceptable; its most important effects, with minor exceptions, are not immediate but cumulative and long term; its economic toll is insidious and rarely devastating to the younger people who are frequently destroyed by other drugs. Fully 90% of my practice as a thoracic surgeon is involved in treating the ravages of tobacco use on the respiratory and cardiovascular systems.

A person's use of tobacco in this country is considered a right implicitly guaranteed by our Constitution. The talk of legal action to reduce, impede, or stop the use of tobacco is considered seditious. Virtually anyone at any age with 50 to 75 cents can buy a pack of cigarettes, in spite of laws forbiding sales to minors. Even the few limitations legislated are not enforced. And yet tobacco is the number one preventable health hazard today in this country. Its poisons cause carcinoma of the lung and upper airways; increases the risk of carcinoma of the esophagus, bladder, and probably other organ systems; and vastly increases the risk of sudden cardiac death. Smoking by women during pregnancy causes increased perinatal mortality, increased birth defects, increased neonatal cardiopulmonary distress, and possibly a decreased neonatal intelligence. Tobacco is causally related to more deaths than all other drug habits. About 100,000 of the 105,000-115,000 deaths caused by lung cancer this year will be the result of smoking tobacco. Probably 300,000 to 500,000 cardiovascular deaths will be related to smoking. How do we deal with this complex problem? Is there a solution? Simply stopping smoking quickly reduces the risk of sudden cardiac death. Within 5 to 7 years after quitting, the cancer risk of a former smoker closely approaches that of a nonsmoker. The answer, the cure, has to be cessation of smoking.

I think that some government intervention is needed. Strict licensure of outlets might help. Increased user taxation with the proceeds going to defer costs of tobacco-related illnesses might help; dollar-for-dollar contributions by tobacco companies for advertisement for and against tobacco use might help. Perhaps in this era of increased private responsibility for public problems, we should more aggressively strive to educate business leaders regarding their losses due to tobacco consumption by employees. As more and more negative synergistic relationships are found between tobacco use and industrial environmental factors, certainly private industry has much to gain by cessation of smoking by workers.

How long can we publicly (or privately on a corporate level) assume all or part of the responsibility for the personal injury and socioeconomic injury inflicted on themselves and their family, co-workers, friends, and employers by the one-third of our population who smoke? Perhaps the economic facts of life will succeed in the cases where appeal to reason has failed.

Robert A. Wynn, M.D., F.A.C.S.
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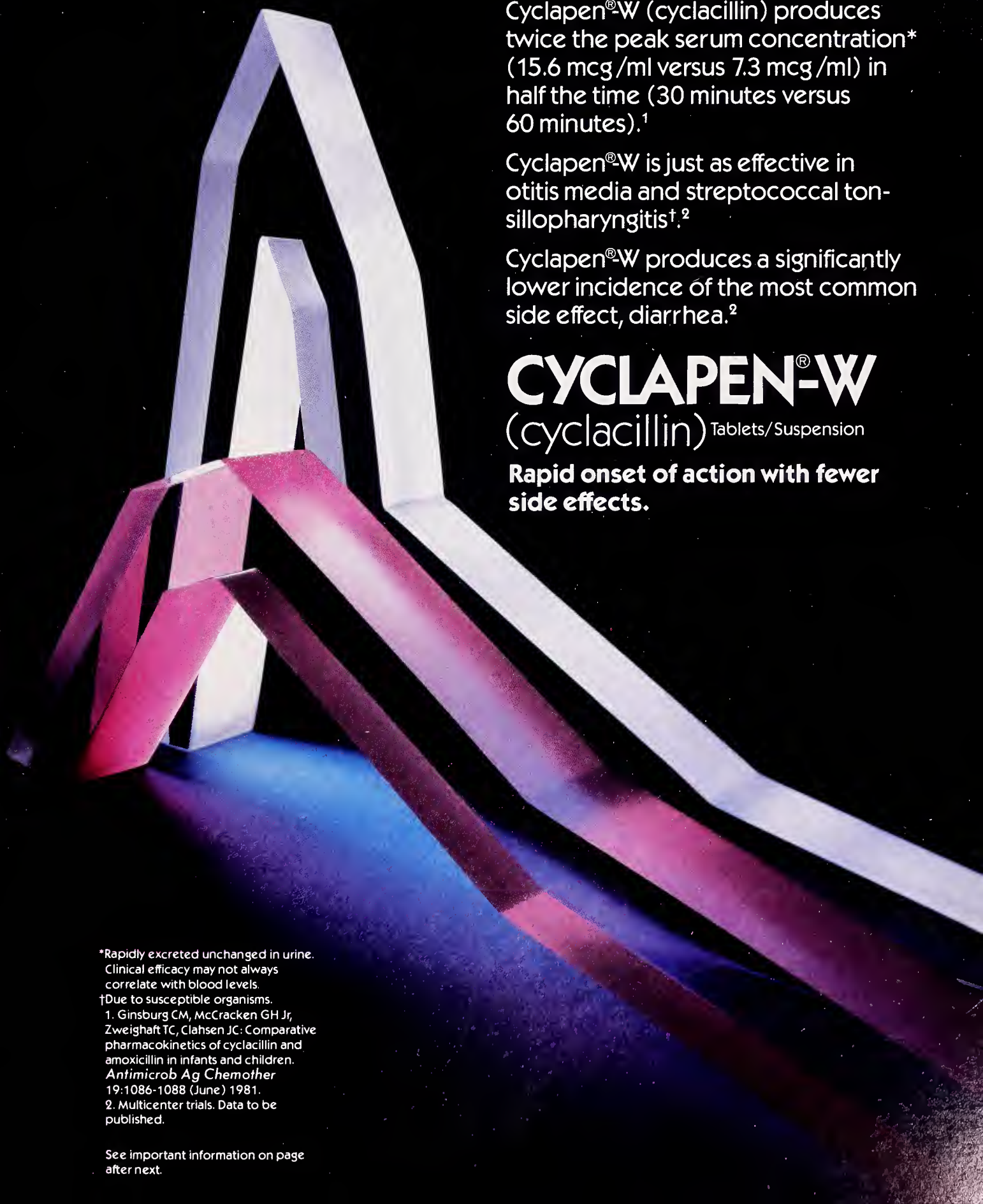
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1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

See important information on page after next.

Compared to ampicillin

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Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.[3]

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Cyclapen®-W (cyclacillin)

Indications
Cyclocillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumania caused by *S. pneumaniae* (formerly *D. pneumaniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumaniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacterialogic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentory) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombacytapenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacterialogic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclocillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Phoryngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumania		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

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Potential Constitutional Issues Raised by the Proposed Amendments to the Georgia Abortion Statute

ROBERT N. BERG, *Atlanta**

At present, the statutory provisions in Georgia relating to abortion provide a general prohibition against the performance of abortions by any person, punishable by imprisonment for not less than 1 nor more than 10 years, together with several exceptions designed to authorize abortions performed by duly licensed physicians, based on their best clinical judgment that an abortion is necessary. Also authorized are abortions performed during the second and third trimesters, if performed in licensed abortion facilities and, in the case of abortions during the third trimester, if performed on the basis of the certifications of the performing physician and two consulting physicians that the abortion is necessary in their best clinical judgment to preserve the life or health of the women. The abortion statute presently in force in Georgia also imposes certain reporting requirements upon the physician performing the abortion.

The present Georgia abortion provisions will be substantially enlarged, however, should the Georgia legislature enact House Bill No. 300, which was introduced into the Georgia House of Representatives on January 21, 1981, and referred to the House Health and Ecology Subcommittee.[1] This Bill, if passed, would impose significant requirements on the physician performing an abortion. Moreover, certain provisions of the Bill, if enacted, may raise interesting constitutional issues.

The Proposed Amendments

The proposed amendments address a perceived need by the Georgia General Assembly, without in any way intending to restrict the right of a woman to obtain an abortion, to prohibit certain conduct and abuses relating to abortions, so as to provide for the health, safety and welfare of Georgia citizens. The amendments would add three new Code sections to the present Georgia statute dealing with abortion.[2]

The first, and most important, of these new Code sections would impose a prohibition on the performance of an abortion by a physician unless the physician first obtained the woman's written informed consent. The Bill specifies that the written informed consent form must be designed to permit a person unfamiliar with medical terminology to understand its purposes and content, and must include certain designated information, including: (i) a description of the stage of development of the unborn child; (ii) the type of procedure which the physician intends to use to perform the abortion; (iii) the possible complications associated with the use

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of the procedure and with the performance of the abortion itself; (iv) the availability of alternatives to abortion; (v) a true copy of the pregnancy test; (vi) the name of the physician performing the abortion; and (vii) a statement that the person's refusal to undergo an abortion does not constitute grounds for the denial of public assistance.

The Bill would require that the consent form be executed at least 24 hours[3] in advance of the time for which the abortion is scheduled, other than in emergency situations. The Bill would also require that the physician performing the abortion maintain the consent form in his files for 7 years from the date upon which the abortion is performed, and destroy the consent form at the end of such 7-year period.

Special provisions are included in the Bill with respect to the performance of abortions on minor unmarried females (less than 18 years of age). Pursuant to the Bill, an unmarried woman less than 18 years of age would be required to obtain the consent of both of her parents, who must base their decision on whether to grant or deny such consent solely upon their child's best interests. The Bill includes exceptions in situations in which only one parent is available for consent, or in which the child has no parents but has one or more guardians.

If the child's parents or guardians refuse to consent, or if she elects not to seek the consent of her parents or guardians, she is authorized to petition a judge of the superior court of the county of her residence to obtain authorization for the physician to perform the abortion. An appropriate hearing is required to be held, and the pregnant woman may obtain an abortion if the judge determines that she is mature and capable of giving informed consent to the proposed abortion, or, if the judge determines that she is not mature, upon his determination that the performance of an abortion would be in her best interest. The Bill also provides that the court may appoint a guardian and/or counsel for the pregnant woman, and would require that the hearing be expedited and given precedence over other pending matters before the court, such that the court may reach a decision promptly and without delay. The judge is required to make written specific factual findings and legal conclusions.

The Bill would add a second new section, prohibiting any person or business entity from soliciting, offering, or receiving any kickbacks or bribes in connection with the performance of an abortion, or receiving any rebate or fee for the referral of an individual to another person in connection with the provision of an abortion. Offenders would be punished by imprisonment for not less than 1 nor more than 5 years, by a fine of not more than $5,000, or both.

Finally, the Bill would add a new section requiring that a physician who diagnoses a woman as having complications resulting from an abortion report his diagnosis and a summary of the woman's physical symptoms to the commissioner of the Department of Human Resources. This report would include, to the extent known by the physician, the identity of the physician performing the abortion or the name or location of the facility where it was performed, along with such additional information as may be required by the Department of Human Resources.

Potential Constitutional Issues

Subsequent to the United States Supreme Court's 1973 decision in *Roe v. Wade*[4] that a woman's right to terminate her pregnancy was a fundamental part of her constitutional right to privacy, numerous related constitutional issues have been raised as a result of attempts by state legislatures to impose restrictions on the rights of women to obtain abortions. Unfortunately, while these constitutional issues have provided a fertile field of debate for legal scholars, they have also posed innumerable problems for state legislators, who have been required to translate broad constitutional mandates into permitted and workable restraints upon the constitutional right of women to obtain abortions. An analysis of some of these constitutional issues, in the context of the restrictions which would be imposed were the Bill to be enacted into law, evidences the types of problems experienced by state legislatures.

Informed Consent — The United States Supreme Court has held, as a general rule, that a requirement imposed by a state that written consent be obtained prior to the performance of an abortion is not unconstitutional, primarily because of the fact that it is both "desirable and imperative" that women make the decision as to whether or not to have an abortion "with full knowledge of its nature and consequences."[5] At the same time, courts have been extremely careful in analyzing the specific details required to be included in the informed consent, and have invalidated as unconstitutional statutory provisions requiring the attending physician to go beyond simply giving information to the patient as to just what would be done and as to its consequences. For example, courts have invalidated provisions requiring that the physician describe the fetus at the gestational point of development at which time the abortion is to be performed, on the grounds that a conscientious physician could not pinpoint the exact point of gestation and therefore would be hesitant to perform any abortions; similarly, a statute which required that the doctor state that "the unborn child is a human life from the moment of conception" was found to be unconstitutional because of the prohibition in *Roe v. Wade* against determinations by the states that life begins at the moment of conception.[6] The provisions contained in the Bill relating to the information required to be included in the written consent form appear to fall in the middle, between the type of "flexible informed consent statutes leaving specific details to the doctor's best judgement" which have been upheld, and the more inflexible statutory requirements which have been struck down by the courts because they "might well confine the attending physician in an undesired and uncomfortable straightjacket in the practice of his profession."

A second constitutional issue which has been raised involves a requirement, such as that found in the Bill, that the informed consent be followed by a designated waiting period, so as to allow the pregnant woman to reconsider her decision to obtain an abortion. On the one hand, courts have found both 24 and 48-hour waiting periods to be unconstitutional, in that they (i) resulted in requiring women who traveled a significant distance to obtain an abortion to stay over an extra day or make a second trip, and (ii) increased the risk to the pregnant woman's health, both of which constituted, in the eyes of the courts, direct obstacles to the obtaining of an abortion and therefore unconstitutionally imposed restraints by the state.[7] On the other hand, other courts have found that the state interest in allowing a woman to have time to consider her decision after signing the consent form constituted a legitimate and reasonable restraint, and thereby upheld similar waiting periods.[8]

Parental Consent — The Supreme Court has held that a state may not impose a blanket provision requiring the consent of a parent or guardian as a condition for the obtaining of an abortion by an unmarried minor, in that a state does not have the constitutional authority to give a third party an absolute and possibly arbitrary veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding the consent.[9] However, the requirement that a pregnant minor obtain parental consent to an abortion has been constitutionally upheld, if and only if it provides an alternative procedure whereby authorization for the abortion can be obtained. In most cases, states have opted to use a judicial procedure similar to that set forth in the Bill as the "alternate procedure" required by the Supreme Court.

Court Procedure — However, states have run into problems in connection with the specific provisions of the "alternate procedure," for several reasons. Initially, several courts have invalidated statutory court procedures as a result of the fact that these procedures authorized the judge to decide that, even though the pregnant woman was mature enough to make an informed decision, it would not be in her best interest to obtain an abortion. The Supreme Court has expressed quite clearly that, if the judge finds that the pregnant woman is mature enough to make an informed decision, the judge is not allowed to make an independent decision concerning what is in the pregnant woman's best interest; rather, the judge may

only determine what is in the woman's best interest if he finds that she is not mature enough to make her abortion decision.[10]

Court procedures contained in state abortion statutes have also been invalidated because they fail to provide speedy, non-burdensome, and anonymous procedures whereby a minor can obtain judicial authorization for an abortion. For example, statutes have been held unconstitutional to the extent that they do not provide for the appointment of counsel, do not guarantee speedy procedures (such as provisions for expedited review), do not provide any safeguards for preserving the anonymity of the pregnant minor, and the like.[11]

Reporting Requirements — In general, courts have upheld abortion statutes containing reporting requirements, primarily because the submission of abortion reports has been found not to be unconstitutionally burdensome. However, courts have invalidated abortion statutes which do not contain procedures so as to allow "identifiers" to be deleted or removed from the required reports. These courts have found that the inclusion of identifying information, such as the name and address of the woman who obtained an abortion, unconstitutionally "chilled" the woman's right of privacy.[12]

In summary, states must be exceedingly careful in adopting abortion statutes so as to avoid imposing unconstitutional, impermissable restrictions upon the right of a woman to obtain an abortion. The Georgia legislature will certainly have these constitutional issues in mind in analyzing, drafting, and debating the Bill.

Notes

1. H.B. 300 was not acted upon by the House during the 1981 legislative session and therefore was carried over to the 1982 legislative session.
2. *Ga. Code Ann.* §§26-1205, 1206, and 1207.
3. A substitute bill offered by the House Committee would shorten this "waiting period" to two hours; this change would be significant, in light of the constitutional issues discussed, *infra*.
4. 410 U.S. 113 (1973).
5. *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976); see, also, *Margaret S. v. Edwards*, 488 F.Supp. 181 (E.D. La. 1980).
6. See, e.g., *Roe v. Wade, supra*, 410 U.S. at 159, 162; *Margaret S. v. Edwards, supra*, 488 F.Supp. at 208-210.
7. See, e.g., *Women's Services, P.C. v. Thone*, 483 F.Supp. 1022 (D. Neb. 1979); *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft*, 483 F.Supp. 679 (W.D. Mo. 1980); *Margaret S. v. Edwards, supra*.
8. See, e.g., *Wolfe v. Schroering*, 541 F.2d. 423 (6th Cir. 1976); *Akron Center for Reproductive Health, Inc. v. Akron*, 479 F.Supp. 1172 (N.D. Ohio 1979).
9. *Belloti v. Baird*, 443 U.S. 662 (1979).
10. *Id.*, 443 U.S. at 643-649.
11. See, generally, *Annotation*, 52 L.Ed. 2d. 892.
12. See, *Planned Parenthood of Missouri v. Danforth, supra*.

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In the treatment of impetigo–

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

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Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus,* 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes,* and 1% beta-hemolytic *Streptococcus*.‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:
Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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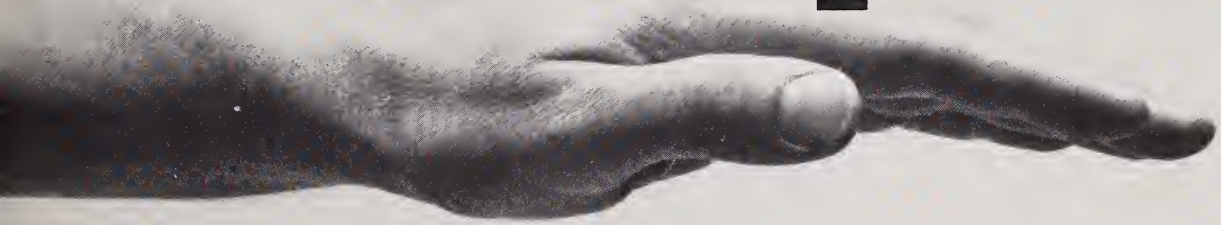
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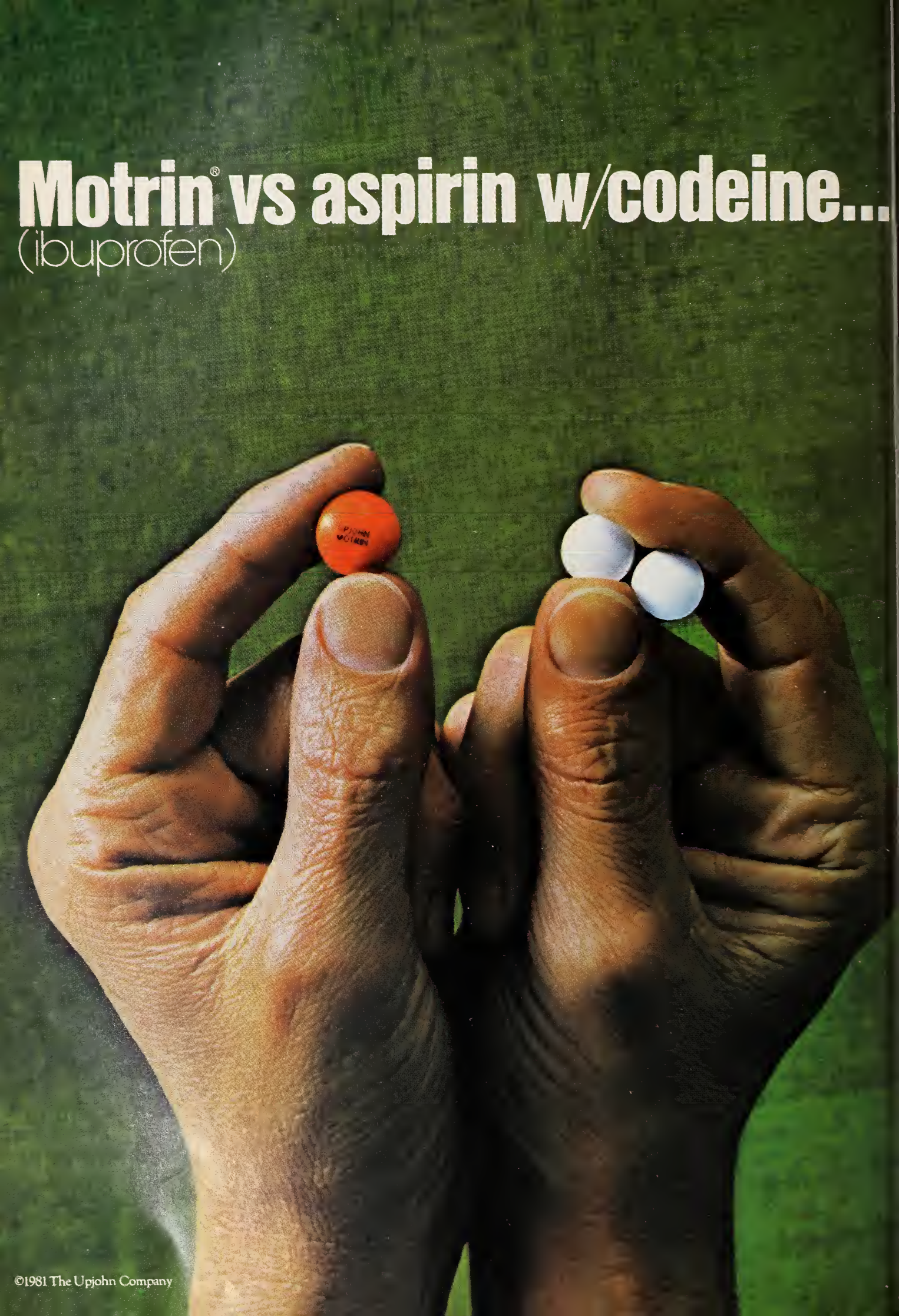


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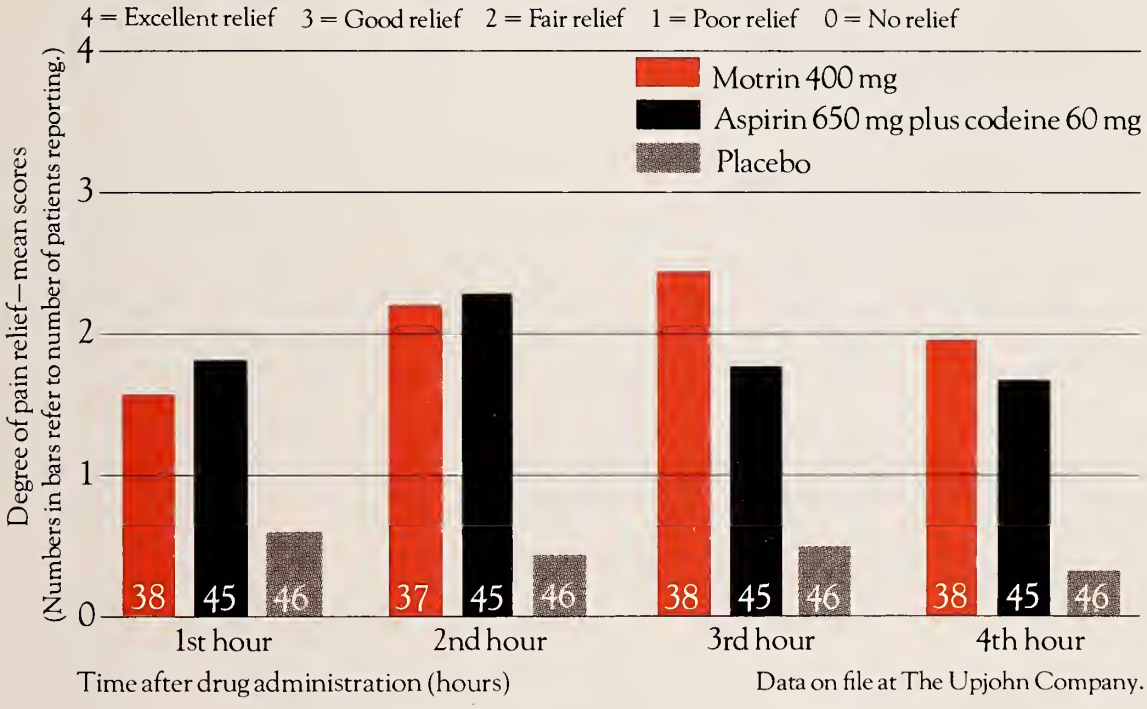


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compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
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One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

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Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

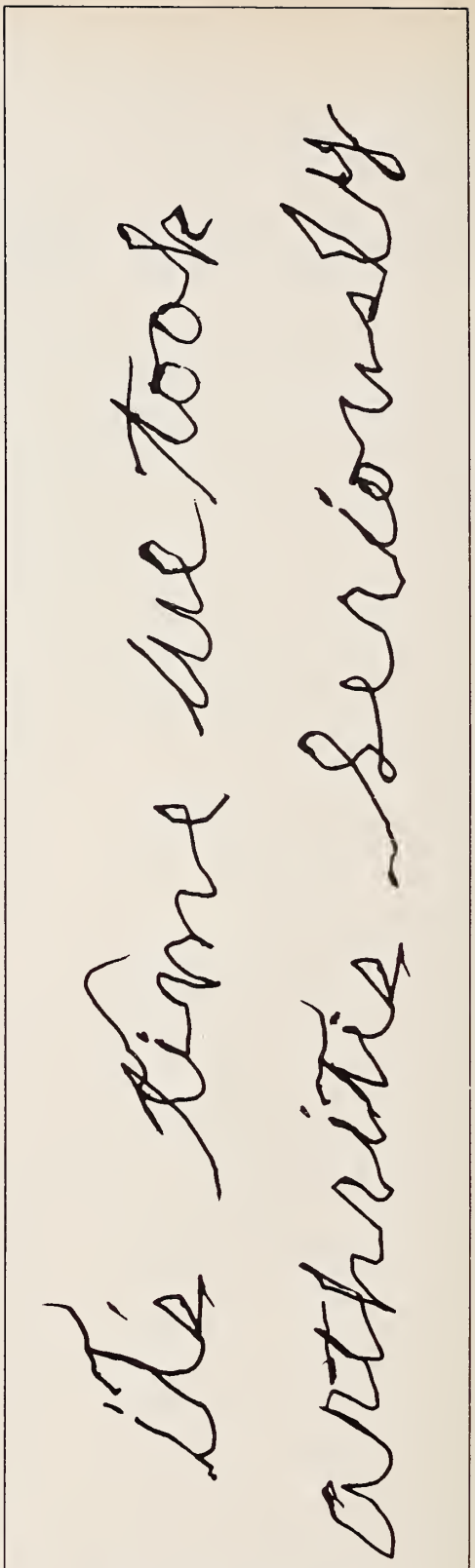
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heart page
heart page
heart page

Multiple Risk Factor Intervention for Prevention of Coronary Artery Disease

LAURENCE O. WATKINS, M.D., M.P.H., *Augusta**

Introduction

THE MULTIPLE RISK FACTOR INTERVENTION TRIAL (MRFIT) is a collaborative clinical trial of 22 clinical centers in the United States. A total of 361,662 men aged 35-57 were studied from 1974 to early 1976. On the basis of serum cholesterol, blood pressure, and smoking habits, the probability of dying from coronary artery disease (CAD) within the next 6 years was estimated for each individual, using formulae derived from the Framingham data. Study participants were selected from the upper 15% of the risk spectrum. A total of 12,866 men, free of symptoms of CAD, were allocated randomly to two study groups of approximately equal size, Special Intervention (SI) and Usual Care (UC). The trial will determine whether reduction of serum cholesterol by dietary intervention, decreased cigarette smoking, and drug or dietary treatment of hypertension resulted in a reduction of mortality due to CAD in SI over UC participants over a follow-up period of 6 years. Other end points to be assessed are myocardial infarction and total mortality. The SI group received a program of nutrition counseling, modification of smoking behavior, and drug and/or dietary treatment of hypertension as in the Hypertension Detection and Follow-up Program (HDFP). Participants in the UC group were referred to their personal physicians and received whatever treatment these physicians thought appropriate.

Materials and Methods

In the July, 1981, issue of *Preventive Medicine,* a series of eight papers by the staff of MRFIT provided a detailed review of the protocol, the methods of intervention, the risk factor changes, and a comparison of the Special Intervention and Usual Care groups at the end of 4 years. This paper will summarize these interim findings and comment briefly on some of the implications for the practicing physician.

The SI was intended to achieve simultaneous, rapid, and drastic reduction in all three risk factors, so as to ensure maximum preventive effect over the duration of the trial. In MRFIT, there was an integrated approach to life-style change, but for each risk factor there were specific objectives delineated and specific methods prescribed for achieving a change in lifestyle and a reduction in risk factor levels. The nutrition intervention programs sought to modify the participants' eating habits so as to reduce the percentage of calories from total fat and from saturated fats, to

*Dr. Watkins is Assistant Professor of Medicine, MCG, Augusta, GA 30912. Send reprint requests to him. Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

increase the percentage of calories from polyunsaturated fats, to decrease the amount of cholesterol consumed, and to modify the consumption of carbohydrate and alcohol. For hypertension, a stepped-care system was used. This included weight control and sodium restriction and the use of specified drugs as in the HDFP. The goal of the cigarette smoking intervention program was cessation of smoking, but lesser end-points were sought if cessation could not be attained. A number of innovative methods derived from the field of behavior therapy and intervention were used to accomplish the SI. These included participation in 10 weekly group sessions, self monitoring, provision of frequent feedback and positive reinforcement. In particular, the support of the participant's wife or homemaker was enlisted by having her join the groups if possible. This facilitated the necessary dietary changes and also provided support for smoking cessation and adherence to hypertensive drug therapy.

Results

One sixth of the SI group adhered very closely to the prescribed diet. On average, and in comparison to pre-trial values, the intake of saturated fat declined by 28.4%, polyunsaturated fat intake increased by 36%, and dietary cholesterol decreased by 42.5%. The mean weight loss in the SI group after 4 years was 3.3 pounds. The mean serum cholesterol in SI and UC participants at first screening was 254 mg/dl. At 4 years, it had decreased by 18.4 mg/dl in the SI group and by 10.2 mg/dl in the UC group. Those who lost weight showed a greater fall in serum cholesterol than those whose weight remained unchanged or increased. Reductions in total and LDL-cholesterol were greater in the nonhypertensive than the hypertensive subgroups. Smokers who continued to smoke had smaller lipid responses than nonsmokers, while those who stopped smoking displayed an intermediate level. Substantial increases in HDL-cholesterol occurred only in the nonhypertensive group and especially among those who stopped smoking.

Smokers participated in a program that offered both group and individual formats as well as a maintenance program for those who stopped smoking. Of 4,103 SI smokers, 45.9% had stopped at 4 years, compared to 23.9% of the UC smokers. Light smokers (0-19 cigarettes/day) stopped more readily and relapsed less often. The smoking intervention was the most successful. Some of the techniques are described in the Helping Smokers Quit Kit provided by the Department of Health and Human Services.

Of the 5,790 SI men examined at the fourth annual visit, 3,696 had been hypertensive. More than 80% had diastolic blood pressures (DBP) less than 90 mm Hg and were taking antihypertensive drugs. The mean DBP reduction in the SI group was 9.4 mm, and in the UC group, 5.2 mm. Older men and men with higher blood pressure levels at entry had better responses. These results compare favorably with those of the HDFP.

Implications for the Physician

In conclusion, the risk factor changes obtained at the end of 4 years appear to justify simultaneous multifactor intervention. It was observed that intervention on one risk factor might have adverse effects on the level of another, or at least affect the magnitude of the response to intervention on the latter. Thus, simultaneous intervention was required in order to affect an individual's risk to a significant extent. For example, poorer responses of plasma cholesterol have been associated with diuretic therapy. Thiazide diuretics attenuated the effect of the dietary intervention. However, without dietary intervention, higher cholesterol levels would have resulted. Similarly, smoking cessation was often accompanied by weight gain because of increased caloric intake and by a failure to adhere to the MRFIT eating style. This had adverse effects on both blood pressure and serum cholesterol levels.

MRFIT will continue until March of 1982. In the ensuing months, statistical analyses will determine whether significant differences in CAD outcomes exist between SI and UC groups. Except for smoking changes, the observed differences

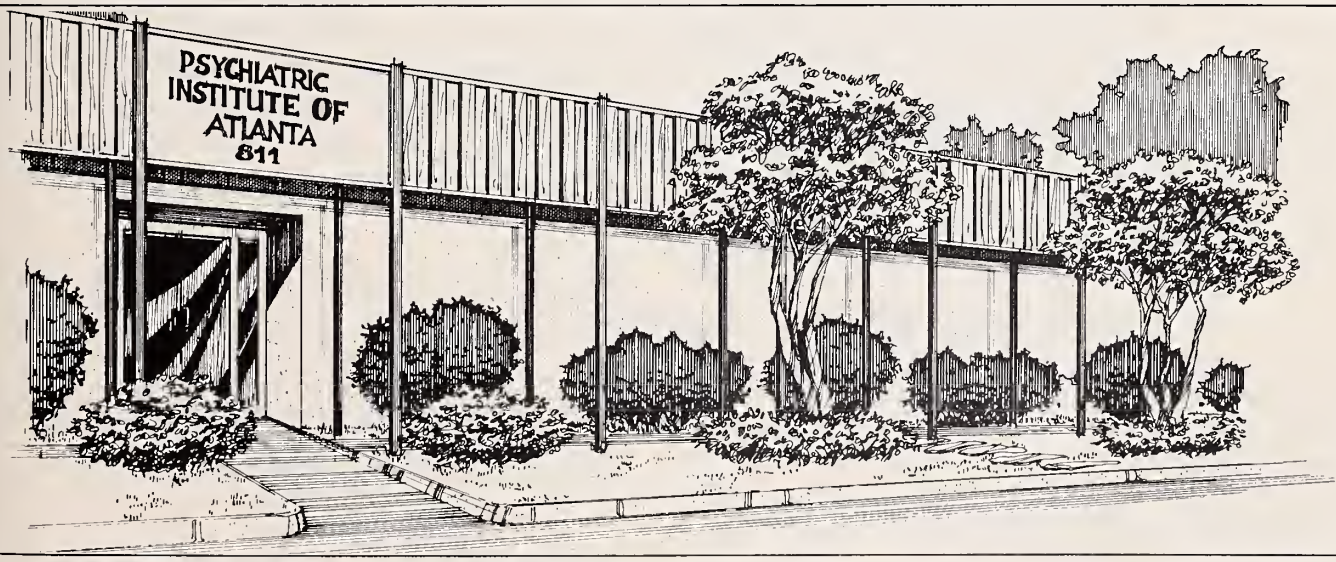
in risk factors between the groups have been less than expected. It is possible that this type of risk factor reduction would not result in a decline in CAD incidence and mortality. As Jeremiah Stamler has pointed out, "such a result would not represent a decisive test of the role of lifestyles in general and "rich" diets in particular in the etiology of the disease since it is entirely possible that such a result would be a consequence of "too little and too late." . . . Should its result be positive, it will have great practical significance as a direct demonstration of our ability to influence the course of the disease even when the individuals are at very high risk and the limited intervention efforts are begun only in middle age."[1] The extent of the changes in the UC group suggests that a positive conclusion is anticipated by many physicians. Suggested reading materials are listed in the References that follow.[2-4]

References

1. Stamler J. Lifestyles, major risk factors, proof and public policy. Circ 1978; 58, 3-19.
2. American Heart Association Committee Report. Risk factors and coronary disease: a statement for physicians. Circ 1980; 62, 449A-455A.
3. Report of Task Force #2. The physician in the office (adult medicine), Proceedings of 11th Bethesda Conference: Prevention of Coronary Heart Disease. Am J Cardiol 1981; 47, 747-751.
4. Helping Smokers Quit: A Guide for Physicians. DHEW Publication Number (NIH) 79-1825.

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president's letter



If It Ain't Broke — Don't Regulate It

THERE ARE PROBABLY a few relatively simple things that should properly be taken care of by the government, which with great effort and concentration it could do well. Health care, however, is not one of them. Our government, with its penchant for rewarding inefficiency with large guaranteed loans and "punishing efficiency with strangling regulations, has decided that health care, although admittedly excellent, is nevertheless too costly. Apparently, those free-spending legislators and administrators believe that the gross national product cannot support all their wants and health care too. The new proposal is to encourage competition in health care and thereby reduce costs.

This idea is not inherently bad, but it is difficult to put a lot of faith in its efficacy in light of the track record of similar, previous legislation. A government that can come up with 40,000 different regulations specific to the humble hamburger could easily reduce the efficiency of health care delivery to that of the postal service.

The medical profession and hospitals have worked hard to reduce costs while keeping quality intact, and both will and should continue to do as much as possible in this regard. We must stay informed on developments and use all our considerable influence to keep the government from doing more for the country's health care than is necessary. If it ain't broke — don't regulate it.

L. Newton Turk III M.D.

L. Newton Turk, III, M.D.
President, M.A.G.

NEW MEMBERS

Agrawal, Bipin, Muscogee—ACT— IM/NEP
401 Doctors Bldg., Columbus 31901

Allen, Edwin W., III, Dougherty—ACT (N-1)—EM
Phoebe Putney Memorial Hospital, Albany 31702

Calhoun, William M., Sumter—ACT—FP
723 W. Forsyth, Box 329, Americus 31709

Carson, Larry V., Richmond—I&R—NS
Dept. of Surgery, MCG, Augusta 30912

Chism, Newton W., Laurens—ACT—OBG
Erin Office Pk., Dublin 31021

Conklin, Harvey B., Georgia Medical Society—ACT (N-2)—EM/GS
Emergency Dept., St. Joseph's Hospital, Savannah 31406

Hand, Charles R., Muscogee—ACT—ORS
1920 Warm Springs Rd., Columbus 31995

Henderson, Warren J., Jr., Troup—ACT (N-2)—IM
303 Smith St., LaGrange 30240

Hutchinson, Charles L., Cobb—ACT (N-2)—PD
4001 Canton Hwy., Ste. 6, Marietta 30066

Khoury, Nicholas F., Muscogee— Service—OBG
P.O. Box 622, Martin Army Hospital, Ft. Benning 31905

Kirtley, Thomas L., Jr., Muscogee— Service—FP
197th Infantry, Family Practice Clinic, Ft. Benning 31905

McFarland, John H., Floyd-Polk-Chattooga—ACT—FP
302 Turner McCall Blvd., Rome 30161

Marsh, Duncan R., Dougherty—ACT (N-2)—ORS
810-14th Ave., Albany 31708

Miller, S. Jones, Troup—ACT (N-2)—OBG
303 Medical Dr., Ste. 403 and 405, LaGrange 30240

Poulos, Phillip R., Dougherty—ACT (N-2)—IM
1700 E. Broad Ave., Albany 31705

Rao, S. H. V., Laurens—ACT—IM
VA Medical Ctr., Dublin 31021

Rimando, José F., Southeast Georgia—ACT (N-2)—GP
Third St., Glenwood 30428

Sampson, Lloyd B., Muscogee—ACT—D
717-20th St., Columbus 31904

Sanders, Richard A., Muscogee—ACT (N-2)—ORS
6262 Hamilton Rd., Columbus 31904

Thompson, Albert M., Jr., Muscogee—Service—AM/FP
Aviation Medical Family Practice Clinic, Martin Army Hospital, Ft. Benning 31905

Wyant, John R., Cobb—ACT (N-2)
705 Campbell Hill St., Marietta 30060

PERSONALS

First District

Harvey B. Conklin, M.D., of Savannah, opened his first private practice on Hwy. 21 near Goshen Plaza after a long military career. He will practice general medicine and surgery at the Effingham County Hospital. Dr. Conklin retired in 1979 as a Colonel in the U. S. Army Medical Corps.

W. Upton Clary, M.D., neurosurgeon, was honored last December by his Savannah colleagues and friends at a dinner for his 30 years of service. Dr. Clary began his practice in Savannah in 1951.

General surgeon, **Archie J. Morris, Jr., M.D.,** of Vidalia, was elected Fellow in the International College of Surgeons at their Nov. 19 meeting in Coronado, CA. This 12,000 member federation represents 111 nations and is dedicated to the international exchange of surgical knowledge through education and humanitarian activities.

Fourth District

Family practitioners, **Lawrence L. Freeman, M.D.,** of Chamblee, and **Carl H. Strom, M.D.,** of Decatur, were elected to offices in the Georgia Academy of Family Physicians. Dr. Freeman was named Fourth District Director and Dr. Strom, Alternate District Director. Decatur family physician, **Andy Morley, M.D.,** was elected as an alternate delegate to the American Academy of Family Physicians Congress of Delegates.

Fifth District

David F. Apple, Jr., M.D., of Atlanta, who is president-elect of the American Spinal Injury Association, will head the new Shepherd Spinal Center slated to open in February, 1982. The center was previously based at West Paces Ferry Hospital before moving to a new facility on Peachtree Rd., next to Piedmont Hospital.

Riverdale surgeon, **Stephen P. Auda, M.D.,** was designated Fellow of the International College of Surgeons at its meeting held last November in California.

Daniel Hennessey, M.D., ophthalmologist, joined the Peachtree Eye Clinic for Tuesday afternoon office hours. He also practices ophthalmology in North Atlanta.



Dr. Kaufmann

Specialist in internal medicine and cardiology, **James A. Kaufmann, M.D.,** was recipient of the Aven Cup, the Medical Association of Atlanta's highest award for community service. A native of Detroit, Dr. Kaufmann is a graduate of Vanderbilt University and the University of Tennessee College of Medicine in Memphis. Dr. Kaufmann received the award for his outstanding service and leadership within the broad areas of health, religion, public affairs, education, and cultural activities.

The Aven Cup Award was established in 1954 "to recognize and encourage participation in civic and community affairs by members of the medical profession in Atlanta." As reported in the Dec. 16 *Atlanta Constitution,* Dr. Kaufmann "is truly one of the most dedicated citizens of this city and state."

The Journal of Medical Genetics, a British medical journal, gave the name "Patterson Syndrome" to a set of birth defects first revealed about 2 decades ago by **Joseph H. Patterson, M.D.,** an Emory physician. Dr. Patterson is chief physician at Henrietta Egleston Hospital for Children, an affiliate of Emory's Woodruff Medical Center.

John T. Yauger, M.D., an Atlanta internist, was installed as the 1982 president of the Medical Association of Atlanta at its annual banquet on December 15.

Sixth District

M. Julian Duttera, Jr., M.D., was elected to the Georgia Division, American Cancer Society Board of Directors. Dr. Duttera is currently director of the Enoch Callaway Cancer Clinic in LaGrange.

Andy Wilkerson, M.D., of LaGrange, was admitted recently as a Diplomate of the American College of Obstetrics and Gynecology. Dr. Wilkerson joined the staff of the Clark-Holder Clinic in May of last year.

Seventh District

In a December 3 article in the "People" section of the *Atlanta Constitution,* **Ronald Bloodworth, M.D.,** Director of the Psychiatric Institute of Atlanta, was among those interviewed on the subject of depression and suicide in children and adolescents. He said that children and adolescents may show their depression through such activity as hyperactivity, truancy, aggression, or excessive drug use — thus differentiating their depression behavior from that of adults.

Carlton D. Lancaster, Jr., M.D., resumed his practice in Dalton after several weeks' leave of absence last October and November. Dr. Lancaster spent his leave studying newer methods of treating diabetes mellitus in Atlanta at the Diabetes Unit at Grady Hospital, and at the Diabetes Clinic at Emory University. Dr. Lancaster, Board certified in internal medicine, is a charter member and a director at the local chapter of the American Diabetes Association.

Eighth District

Brenda Thomas, M.D., Waycross pediatrician, was named as a Fellow of the American Academy of Pediatrics recently. Dr. Thomas attended South Georgia College in Douglas, the University of Georgia, and the Medical College of Georgia. She served her residency at Shands Teaching Hospital, University of Florida in Gainesville.

Ninth District

Raleigh Garner, M.D., of Gainesville, was honored at a reception in November by friends at Chicopee Manufacturing Company for his service in the community. Also, the Hall County Commission set aside a day as "Dr. Raleigh Garner Day." Dr. Garner spent 41 years of service to Chicopee employees before his retirement last September.

Pediatrician, **A. Rahman, M.D.,** opened a practice on September 1, 1981, near Gwinnett Community Hospital on Fountain Dr. near Snellville. She has staff privileges at Gwinnett Community Hospital, the three hospitals in the Gwinnett Hospital System, and has applied for privileges at DeKalb General Hospital. Dr. Rahman graduated from the medical school and completed her internship in her native India, the University of Allahbad, before completing her residency at the Hurley Medical Center in Flint, Michigan.

SOCIETIES

The Bibb County Medical Society's newly-elected officers are as follows: Milton I. Johnson, Jr., M.D., president; C. Emory Johnson, Jr., M.D., president-elect; William P. Brooks, M.D., vice-president; Jimmy R. Asbell, M.D., secretary; and Alex R. Mitchell, M.D., treasurer.

Claud A. Boyd, Jr., M.D., was installed on December 15 as the 1982 president of the **Richmond County Medical Society.** Other officers are as follows: Sumner Fishbein, M.D., president-elect; William E. Barfield, Sr., M.D., vice-president; and Theodora Vanderzalm, M.D., secretary-treasurer.

NOTABLES

The following physicians were reappointed by Governor George Busbee on November 10 as members of the State Medical Education Board: H. Calvin Jackson, M.D., Manchester; Jacob L. Shirley, M.D., Albany; and David A. Wells, M.D., Dalton. They will serve a term of office ending April 1, 1985.

Local physicians, nurses, nurse practitioners, and others volunteered many hours to the Special Olympics Health Fair held last November. Volunteers gave physicals to mentally handicapped youth, enabling them to participate in the Special Olympics Program of athletic competition in Clayton County. The health fair was cosponsored by the Therapeutic Division of Clayton County Parks and Recreation Dept., the Clayton County Board of Education, and Clayton Junior College.

Ron Adamson, PA-C (Physician's Assistant — Certified), of Decatur, was elected to the Board of Directors of the Georgia Association of Physician's Assistants (GAPA) last October. Mr. Adamson was also appointed as Liaison to the Composite State Board of Medical Examiners for the GAPA.

DEATHS

A. G. Funderburk, M.D.

A. G. Funderburk, M.D., of Moultrie, died December 7 at the age of 77 following a lengthy illness. Dr. Funderburk had lived for 46 years in Colquitt County where he practiced medicine and surgery until his retirement in 1971.

Survivors include his wife, two sons, one daughter, one sister, and seven grandchildren.

Carl S. Pittman, Sr., M.D.

Tifton physician, Carl S. Pittman, Sr., M.D., died December 2 at the age of 93. Dr. Pittman was a retired physician and surgeon who had practiced medicine in Tifton since 1919. He was a graduate of Emory University School of Medicine and was recognized by the MAG for his 50 years in practice.

Survivors include his wife, one son, two daughters, four sisters, nine grandchildren, and 12 great-grandchildren.

Trawick H. Stubbs, Sr., M.D.

Atlanta physician, Trawick H. Stubbs, Sr., M.D., died December 7. Retired since 1978, Dr. Stubbs received his medical degree from Emory University School of Medicine and a master of public health degree at Harvard University.

Survivors include his wife, one daughter, one son, two sisters, and two brothers.

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- **MAG Mutual intends to pay 8% interest on each Certificate.**
- **It is the intent of the company to redeem the certificates, subject to the approval of the Insurance Commissioner, as similar companies in other states have already done.**
- **All funds invested in the Surplus Certificates are being held in escrow with the First National Bank of Atlanta.**
- **Physicians will own and control MAG Mutual, while a hired professional insurance staff will handle the daily operations of the company.**
- **MAG Mutual intends to provide professional liability insurance to physicians, their practice entities, and their employees; premises liability coverage will also be available.**
- **MAG Mutual intends to purchase reinsurance so that its liability on any one claim will be limited to about $100,000.**

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from September through December, 1981.*

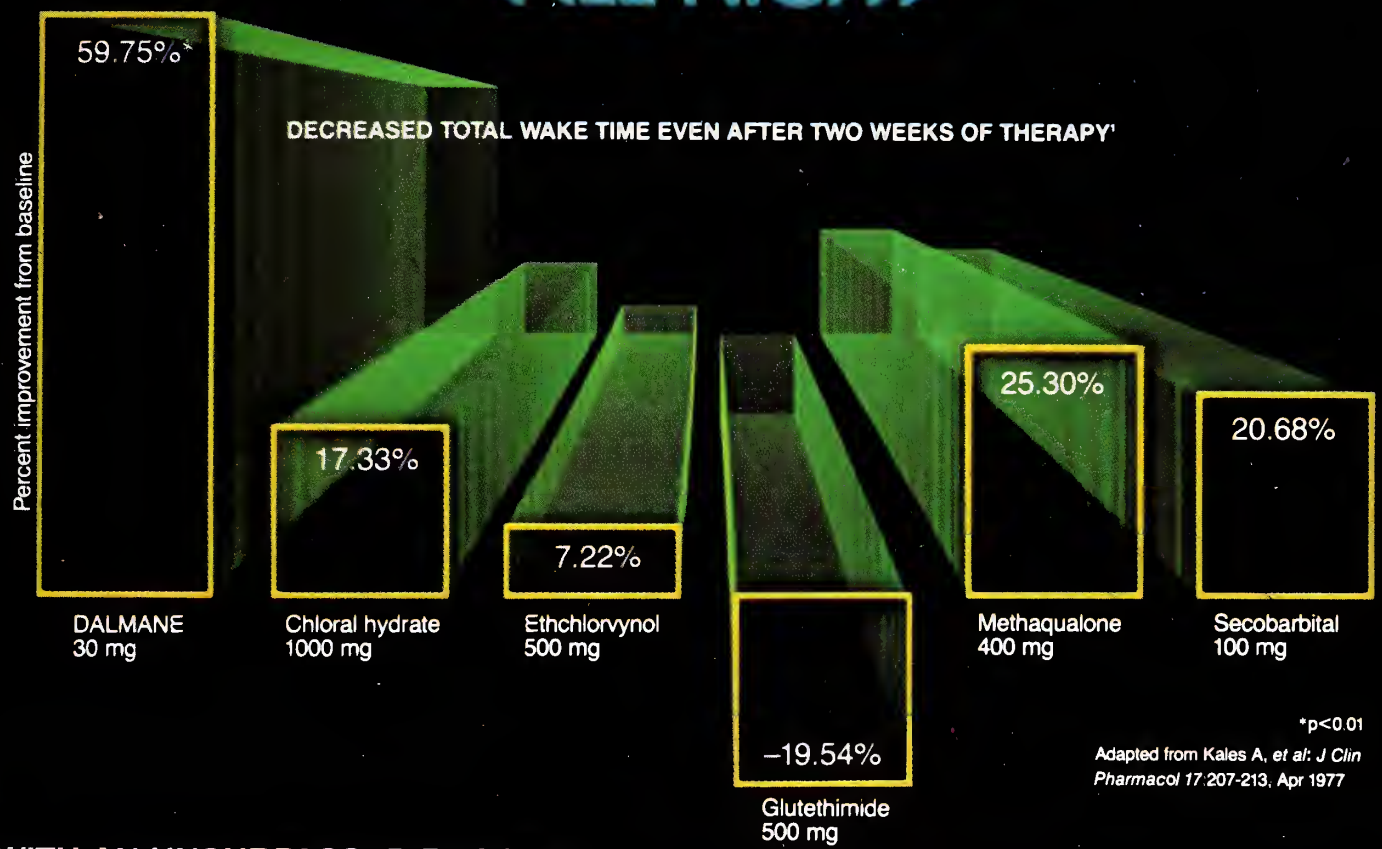
The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category 1 credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Juan Jeronimo Aguilar, Milledgeville
Gabriel M. Alfonso, Milledgeville*
Patrick L. Anders, East Point*
Thomas Seymour Arnold, Augusta
Mohammad Arshad, Atlanta*
Samuel Blank, Decatur*
Charles Emory Bohler, Brooklet*
Larry Bregman, Atlanta
Ruth Cardwell Brown, Atlanta
Barbara A. Bruner, Atlanta*
Carson B. Burgstiner, Savannah*
Milton D. Byrd, Atlanta*
James Andrew Campbell, Fitzgerald*
Diana D. Carr, Augusta
William G. Chambless, Hamilton*
Robert E. Chandlee, Marietta*
Louis G. Chelton, Atlanta*
Eugene Elmore Christian, Milledgeville*
Soong Pyo Chung, Macon*
George Donald Clarke, Savannah*
Henry Tucker Clay, Macon*
William Oscar Cornwell, Fort Oglethorpe*
Carl LeRoy Crawford, Warner Robins*
William D. Crawley, Rossville*
Earl Leo Creech, Valdosta*
Thomas J. Croft, East Point*
Ronald Daitch, Augusta*
Evelio F. Diaz, Milledgeville*
David P. Drotman, Atlanta
Lois T. Ellison, Augusta*
Walter Louis Erhardt, Albany*
Allen Bruce Filstein, Conyers*
David Finkelman, Austell*
Edwin E. Flournoy, Albany*
Miguel A. Fonseca, Savannah
Henry Jack Ford, Athens*
Paul David Forney, Martinez
Thomas R. Friberg, Augusta*
Mark Raphael Funk, Columbus*
Alfredo Gordillo Garcia, East Point*
James S. Garner, Rome
James M. Geeslin, Canton*
John Abner Goldman, Atlanta*
Stephen R. Goldman, Atlanta*
Jose M. Gonzalez, Milledgeville*
Mark Allen Gould, Smyrna*
James T. Grosshans, Atlanta
J. Candler Guy, Atlanta*
David Haim, Columbus
Louis J. Herskowitz, Dunwoody*
Wm. Landrum Heyward, Atlanta
John Christian Hinkle, Augusta
Lovic W. Hobby, Atlanta*
Kenneth W. Horne, Athens*
John Clifford House, Winder*
John Harris Hunt, Savannah
Minh T. Huynh, LaGrange
Willis P. Jordan III, Rome*
James Edward Keehan, Macon
A. Paul Keller, Athens*
Thomas N. Kias, Athens*
Renate Dora Kimbrough, Atlanta
Garland E. Kinard, Rossville*
Gilbert S. Klemann, Albany*
Hilda Knobloch, Savannah
Abraham J. Kravtin, Columbus*
William C. Lang, Jr., Atlanta*
Nolan Maddox Lassiter, Stone Mountain*
Fook Sun Lau, Milledgeville*
Everett Martin Lee, Atlanta*
Sue Kim Lee, Atlanta
Robert M. Levy, Riverdale
Steve Z. Lintymer, Columbus*
James Harvey Litton, Tucker*
Gary Levi Lotner, Jonesboro*
Michael F. Lubin, Atlanta
Lawrence E. Lykins, Gainesville*
Ahmad Shafik Mahayni, Stockbridge*
Joseph A. Manno, Atlanta*
Thomas Windrow Marks, Atlanta*
Louie Woodward Marshall, Martinez*
Frederick Watson Martin, Carrollton
Clinton Edward Massey, Augusta*
John William Mauldin, Lawrenceville*
William L. McDaniel, Dalton*
James Kenneth McDonald, Augusta*
Frederick James Meine, Columbus*
John Glenn Morris, Atlanta
Gerald Bruce Muller, Thomasville*
William Gaither Murchison, Atlanta
James Lawton O'Quinn, Augusta*
Gisak Petrossian, Dublin
Ermete E. Pierleoni, Demorest*
Dionisio A. Pinero, Milledgeville
Quentin R. Pirkle, Atlanta*
R. Burt Prater, Atlanta*
Raimundo J. Ramirez, Tifton*
Humberto C. Ravelo, Milledgeville*
William S. Revell, Louisville
Ralph Donald Roberts, Fitzgerald*
James W. Rogers, Macon*
Philip Richard Saleeby, Brunswick*
M. Aslam Sandvi, Dalton*
Marcelo R. Santiago, Claxton*
John Savino, Savannah
Robert Lowell Schwin, Atlanta*
Walter H. Shehee, East Point*
Lee Raymond Shelton, Atlanta*
Narayan S. Shetty, Commerce*
Nison Howard Shleifer, Atlanta
George B. Skipworth, Columbus*
Carter Smith, Atlanta*
O. Franklin Speaker, Ellijay
Bernard M. Stanfield, Ft. Gordon
Militiadis A. Stefadouros, Augusta
Julian Bernard Tanenbaum, Augusta*
Robert Eugene Thompson, Toccoa*
Martin Lewis Throne, Atlanta*
Patrick David Tisdale, Columbus
Frederick Alan Trest, Augusta*
Frank Owen Underwood, Dunwoody*
Carlos Humberto Vasquez, Cairo
George O. Waring, Atlanta*
Lamar Holman Waters, Clarkesville*
William George Whitaker, Atlanta*
Leslie La Mar Wilkes, Savannah*
Donald Roger Willers, Gainesville*
Edward Dale Wysong, Hartwell*
Robert James Zimmerman, Macon*

* MAG member.

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Tricyclic antidepressants

–which are *not* sleep specific,[9] yet are sometimes used in nondepressed patients for sleep

–which can cause transient insomnia in the elderly[10]

–which can require careful monitoring in cardiovascular patients[10]

–which have strong anticholinergic effects[10]

Antihistamines

–which are *not* reliable sleep-inducing agents[11]

–which may produce stimulation instead[11]

–which have anticholinergic effects[11]

Major tranquilizers

–whose side effects may be troublesome for nonpsychotic patients[12]

–where tolerance for sedation appears rapidly[12]

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.[4]

References: 1. Kales A, *et al: J Clin Pharmacol* 17:207-213, Apr 1977 **2.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **3.** Greenblatt DJ, Allen MD, Shader RI, *Clin Pharmacol Ther* 21:355-361, Mar 1977 **4.** Kales A, *et al: Clin Pharmacol Ther* 18:356-363, Sep 1975 **5.** Moore JD, Weissman L: *J Clin Pharmacol* 16:241-244, May-Jun 1976 **6.** Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **7.** Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, pp. 641-646 **8.** Warfarin Study. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **9.** Baldessarini RJ: Drugs and the treatment of psychiatric disorders, chap. 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp. 391-447 **10.** Cole JO, Davis JM: Antidepressant drugs, chap. 31.2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1941-1956 **11.** Douglas WW: Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap. 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp. 609-646 **12.** Davis JM, Cole JO: Antipsychotic drugs, chap 31.1, in *Comprehensive Textbook of Psychiatry/II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
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Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.
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Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE. *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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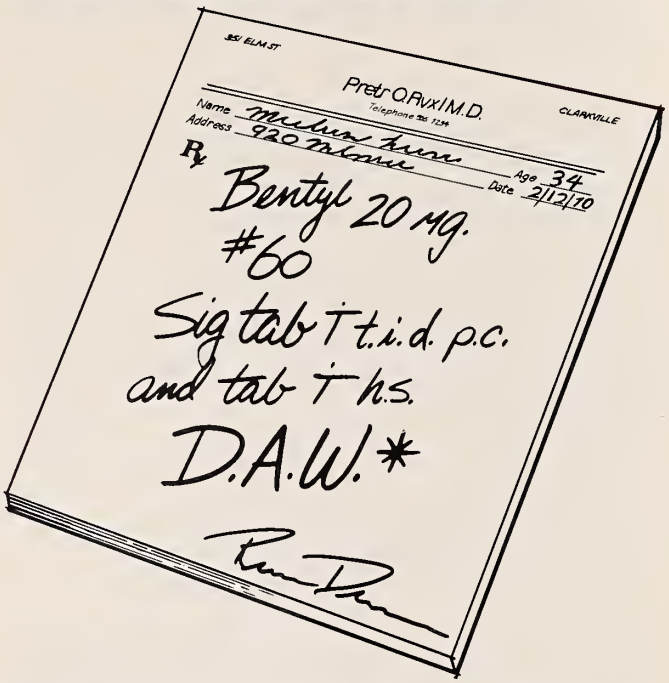
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- The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- Significant pharmacologic effect in the distal colon compared to placebo,[1] shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

is drug has been classified "probably" effective for this indication.

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ference:
Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

ough the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, ce the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result ne sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same rmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste, headache; nervousness; drowsiness; weakness; dizziness; insomnia, nausea, vomiting, impotence; suppression of lactation; constipation, bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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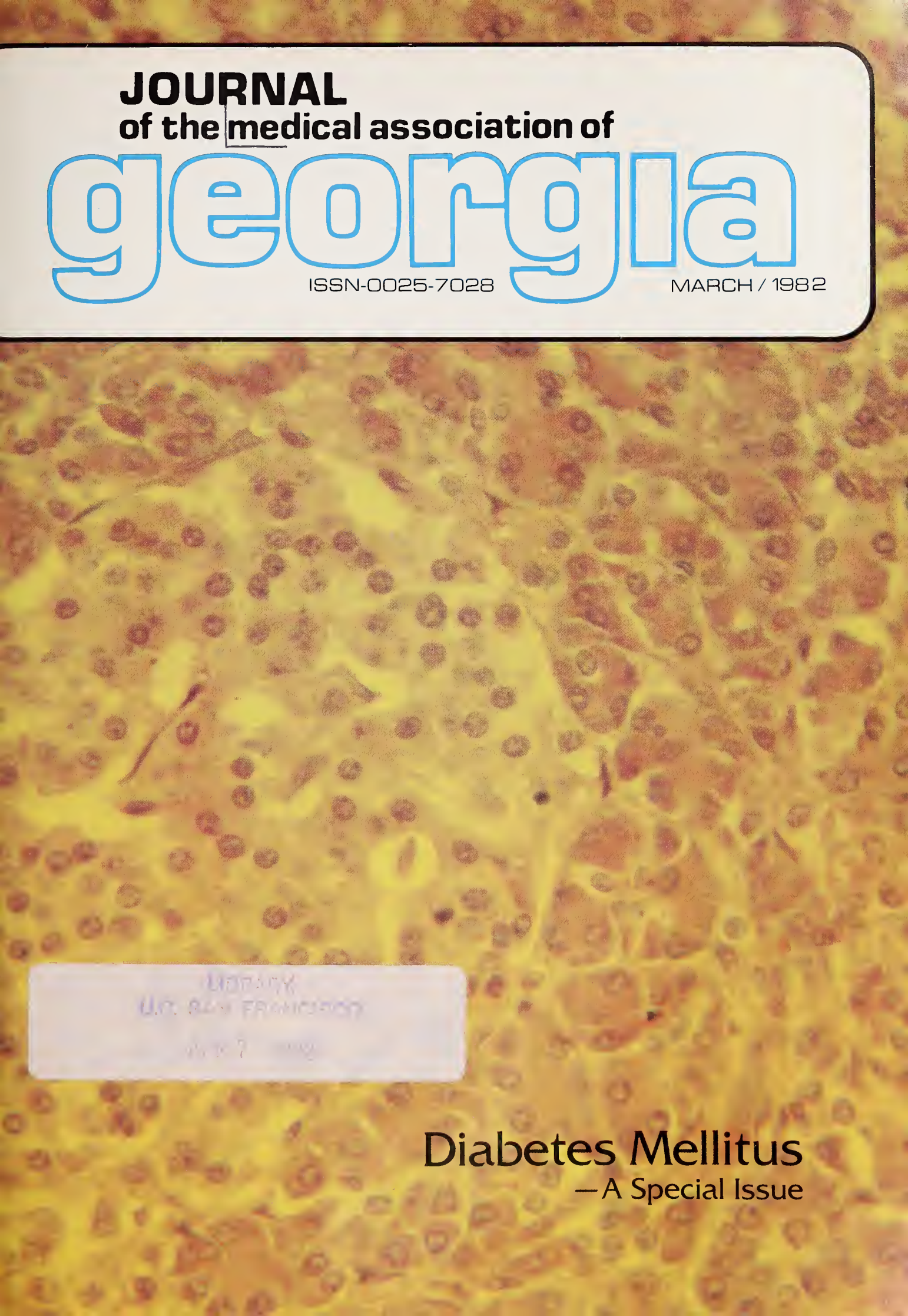
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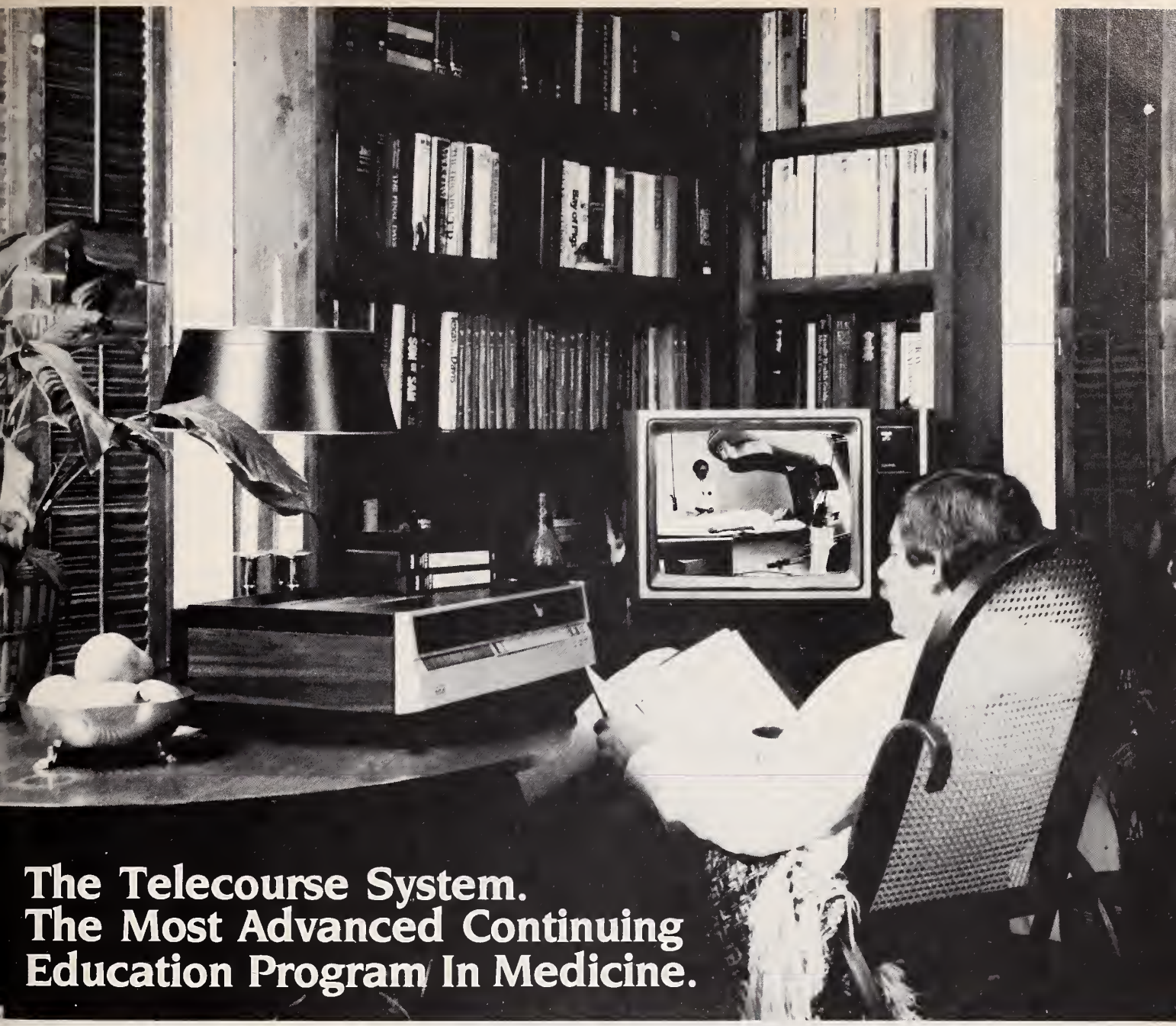
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THE COVER

The cover is a photomicrograph, courtesy of the Department of Pathology, Piedmont Hospital, Atlanta. This section shows a collection of islet cells in the center of the field. Magnification 400x. The stain is hematoxylin and eosin. A collection of papers relating to diabetes is presented in this issue of the *Journal* on the 60th anniversary of the first injection of exogenous insulin to a diabetic patient. Special credit is due to Dr. Roy Wiggins of Atlanta who helped in the preparation of this issue.

Cover artwork by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

Investing in MAG Mutual — Have *You?* Time Is of the Essence

As of March 1, more than $1.5 million have been invested in MAG Mutual Surplus Certificates. Hundreds of Georgia doctors have already made their decision to support MAG Mutual — they have purchased Surplus Certificates. But hundreds have not acted. Unless those who have not purchased certificates do so promptly, the MAG will have to end its support of the efforts at forming MAG Mutual for financial reasons. This project is being funded substantially by the Medical Association of Georgia and has cost nearly $250,000 in direct appropriations and member contributions. Each day costs the MAG up to $1,000, and the MAG cannot continue this drain indefinitely while waiting to raise initial capitalization necessary to "break" escrow.

The decision to purchase a Surplus Certificate is one of the most important issues you face — one that will affect your practice for years. In the organization of MAG Mutual, physicians and others in Georgia have raised various questions about the operations of the Company, its benefits, and its effects on the professional liability climate in the State. These are good questions and ones which the *Ad Hoc* Committee of the Association investigated in its feasibility study as to the forming of the Company.

Q: How Does MAG Mutual Think It Can Save Doctors Money?

A: 1. Physician-owned companies can generate cost savings from lower expenses as a result of efficiencies. MAG Mutual will not pay commissions to insurance agents. Investment income credit will accrue to the policyholders since this is a mutual company. Furthermore, MAG Mutual's profits will be credited to policyholders, not stockholders, as is the case with most commercial insurance companies.

2. Competition also can help save physicians money. The benefits of the free marketplace operate in the insurance industry as in all other industries. MAG Mutual and commercial insurance companies will have to remain competitive in price and service if they are to stay viable and grow.

3. Doctors active in physician-owned companies are personally involved in handling claims and in identifying high risk physicians who generate more than the expected number of claims. Such high risk doctors can be identified and not insured. This can help to reduce costs.

Q: Three or Four Large Lawsuits Could Be Filed in the Next Few Years. How Stable and Secure Is My Insurance With MAG Mutual?

A: 1. The $3 million in initial capitalization is more than twice the amount required by the Georgia Department of Insurance for this type of company.

2. MAG Mutual will purchase reinsurance which limits MAG Mutual's financial exposure on any one claim or series of claims. For example, if MAG Mutual were to acquire reinsurance with a deductible amount of $100,000, reinsurance would pay approximately $900,000 of a $1,000,000 claim.

Q: What Happens to My $1,500 I'm Sending in for the Surplus Certificate?

A: Your $1,500 goes toward the initial capitalization of MAG Mutual which the Company must obtain to begin business. MAG Mutual intends to redeem the Surplus Certificates at some future point, but can do so only out of earnings and upon the approval of the Department of Insurance and the Company's Board of Directors.

Q: May I Finance My Purchase of Surplus Certificates?

A: In the packet which was mailed to you in November and which contained the Prospectus under which the Surplus Certificates are offered, there was included an application form from The First National Bank of Atlanta for an installment loan. This completed application can be sent to MAG Mutual together with your subscription agreement for Surplus Certificates.

Q: What Happens to My $1,500 If MAG Mutual Does Not Raise the $3 Million?

A: Your $1,500 will be returned from escrow plus any interest earned on it less a $10 handling fee for the bank.

Q: Why Should I Switch Insurance From My Current Carrier to MAG Mutual, a New and Untried Company?

A: Physicians as individuals and the medical community will benefit significantly from the presence of a physician-owned company. The financial advantage, market competition, and physician input into claims will all strengthen the position of Georgia's physicians with regard to professional liability insurance. Physicians in other states know that commercial insurance companies pulled out when things got tough. Georgia's physicians can act with foresight by forming a company now to deal with this possibility.

Q: My Insurance Doesn't Expire Until August. Why Should I Purchase a Surplus Certificate Now?

A: MAG Mutual needs to raise the $3 million before it can begin offering protection. By purchasing your Surplus Certificate now, you can help to assure that MAG Mutual will write coverage.

Q: Once the $3 Million Is Raised and a Surplus Certificate Is Issued to Me, May I Transfer It?

A: Surplus Certificates are transferrable through the Company's office to bona fide residents of Georgia, including family members and charitable institutions.

Q: MAG Mutual Is Just Another Place to Get My Insurance — Why Should I Change?

A: MAG Mutual is not just another insurance company. Physician policyholders will control the claims handling process by serving on committees to review claims. And MAG Mutual's primary goal is assuring availability of coverage for Georgia's doctors. As a mutual insurer, the Company will be responsible to its policyholders, not to a separate set of stockholders.

If the formation of MAG Mutual is to succeed, you need to demonstrate your commitment *immediately* by investing in a Surplus Certificate. Anything short of this will force MAG to abandon its support of the efforts to join more than 100,000 of our colleagues in the country who have formed their own insurance companies.

The Surplus Certificates of MAG Mutual Insurance Company are offered by *Prospectus only, and only to individuals whose primary residence and practice entities whose principal place of business is located within the state of Georgia*. If you need an additional Prospectus, or further information, please contact Bert Franco, Executive Vice President, Marketing, MAG Mutual Insurance Company, 938 Peachtree St., NE, Atlanta, GA 30309 (1-800-282-0224).

Report of the Georgia Student Delegate to the AMA Interim Meeting

The American Medical Association (AMA) Medical Student Section (MSS) met for the 1981 Interim Meeting on Friday, Dec. 4, through Monday, Dec. 7, in the Las Vegas Hilton Hotel. Friday afternoon, two student reference committees — on financial aid and parliamentary procedures — listened to their peers presenting testimony on resolutions from the AMA Delegates' Book and from MSS state chapters. On Saturday, these reference committees presented their recommendations to the members of the MSS Assembly, and the student delegates (almost 100 schools were represented) voted on each resolution. On Sunday, the AMA Speaker of the House, Harrison M. Rogers, M.D., officially welcomed the AMA House of Delegates to the 1981 AMA Interim Meeting. Also on Sunday, the MSS sponsored workshops on topics of special interest, e.g. financial aid, legislative affairs, and starting local chapters. On Monday, MSS delegates testified to the AMA reference committees.

The following is a summary of the resolutions adopted by the MSS Assembly and submitted to the AMA for consideration. The resolutions passed were:

—That the AMA House of Delegates request that appropriate *Bylaw amendments* be prepared by the Council on Constitution and Bylaws to provide that the designated member of the MSS Governing Council shall attend meetings of the Board of Trustees with the right of discussion but without the right to vote.

—That the AMA encourage and support the concept of *student-staffed, faculty-supervised community health centers* (Georgia's Student Health Association is an excellent working example of this);

—That the AMA, along with the MSS and the Resident Physicians' Section, use questionnaires to *research the effects of indebtedness on career choices of medical students;*

—That the AMA establish a voluntary $10 contribution by physician, resident, and medical student members for a *new student loan program*, and that the AMA *seek matching funds from private organizations*, and that this AMA-ERF (Education & Research Foundation) student loan fund subsidize interest on, as well as guarantee, medical student loans (currently, existing funds are being used to pay off defaults);

—That the MSS Governing Council, in association with appropriate AMA policy-making bodies and staff, *investigate the feasibility of offering loans to senior medical students* through private insurance companies;

—That the MSS Assembly communicate to the AMA that the Board of Trustees Report JJ (from the Annual Meeting, '81), on the *current loan situation*, is only a preliminary statement that outlines positions which need to be supported with concrete action and continuing reports in the future (an MSS *Ad Hoc* Committee on Financial Aid was formed in September to further research the status of the many loan and scholarship programs available to medical students — their report was extensive and adequately demonstrated the urgency of the decreased federal funding situation);

—That the AMA study the proposals set forth in the Report to the Congress by the Comptroller General entitled, "Will there be enough trained medical personnel in case of (nuclear) war?"

The *drafting of health professionals and incorporation of civilian hospitals into military hospitals* (i.e. the Civilian-Military-Contingency Hospital System) deserves special scrutiny;

—That the MSS Assembly *support the Council on Medical Education's Report B* (from the Interim Meeting, '81), which opposes the use of FLEX I-FLEX II exams as a substitute for the National Board of Medical Examiners, Parts I, II, and III, as a gateway examination for entry into graduate medical education, and as the sole route to medical licensure;

—That the AMA support a reaffirmation of Affirmative Action in recruitment, retention, and graduation of minorities by all medical schools;

—That the AMA reaffirm its existing policy that *geriatric medicine* be incorporated into curricula of the major medical school departments;

—That the AMA support a *10% per package increase in the cigarette excise tax that would be paid directly to the Medicare Hospital Insurance Fund* (so that non-smokers should not bear the total cost of illness incurred by smokers);

—That the AMA recommend that all hospitals accredited by the *Joint Commission on Accreditation of Hospitals (JCAH),* provide their medical students, house staff, and attending physicians with a list of commonly ordered diagnostic tests and prescribed medications with their corresponding costs to patients;

—That *the parliamentarian* present at the business meetings continue to be an elected student and not a hired professional parliamentarian;

—That the *tenure on the Governing Council* of the MSS continue to be for two years (not reduced to one year), to achieve the most effective representation of student interest to all parts of the AMA.

Student and resident representation on the AMA Board of Trustees was perhaps the major issue at this meeting. Much vocal and influential support on behalf of this student resolution was offered to the AMA reference committee on Monday, Dec. 7. Unfortunately, the reference committee recommended inviting student and resident participation on the Board, "whenever . . . their agenda indicates a need for a contribution from these Sections," which was the existing, unstated situation. There were twelve other resolutions introduced by the MSS to the AMA House of Delegates: five were defeated outright, five were referred to the Board of Trustees for further study, and two were amended and adopted.

The experience was that of an action-packed weekend, with a group of energetic, highly focused students who worked hard to consolidate and present their ideas to the AMA House of Delegates. It was a tremendous educational experience for me as an introduction to organized medicine. Coming to grips with the parliamentary procedure was no small task; I admired its usefulness as a tool to facilitate large group decisions. Ironically, the MSS resolution on whether to hire a parliamentarian became so hotly debated that, had it not been for our own elected student parliamentarian reading the rules book, the debate might have degenerated into a less civilized means of communication.

It was a unique privilege to be associated with so many articulate students, and to know that so many students around the country have such a deep interest in contributing to organized medicine. The Southern region needs to be encouraged to increase its student participation at the state and local levels.

K. Krämer
Student, Class of '84
Medical College of Georgia

The Medical Association of Georgia — A Short History

ORGANIZED MEDICINE actually began in Georgia with the founding of a regional group, the Georgia Medical Society (Chatham County) in 1804, which was one of the first such organizations in the country. A similar organization was put into operation some years later in Richmond County when the Medical Institute of the State of Georgia was begun in 1828, later becoming the Medical College of Georgia in 1833. Several other small county groups followed.

But it was not until 1849 that the first state medical association became a reality. A previous effort to organize such a group, known as the Central Medical Society, had held only two or three meetings in Milledgeville before it folded. It was said that the organizational effort failed because the county medical societies then in existence in Georgia were not invited to participate in the affairs of the group.

In 1849, Georgia had a population of 900,000, over half of which were slaves. George Towns was governor at the state capital in Milledgeville, and the state boasted of having the most railroad mileage of any state in the Union, and "the greatest mileage in the world under one management."

The voice of state medicine was the *Southern Medical and Surgical Journal,* established at Augusta in 1839. It was logical, then, for this publication to carry the notice which appeared in February of 1849, to wit:

> "To the physicians of Georgia: The Faculty of the Medical College of Georgia suggest to the medical profession of the state the propriety of organizing an association. Since the establishment of the National or American Medical Association, our sister states, Alabama and South Carolina, have taken action on the subject. It is therefore proposed to call a convention of the physicians of Georgia to be held in the city of Augusta on Tuesday, the 20th of February next, then to adopt such measures for the improvement and benefit of the profession as they may deem proper."

New Jersey had established the first state society in 1788; South Carolina was the first in the South (1789).

The notice in the *Southern Medical and Surgical Journal* also declared that the Georgia Railroad had promptly reduced its fare to one-half for all members of the profession coming to the convention, and that it was presumed the other railroads would do the same. (All three railroads in the state did follow the idea: Georgia Railroad; the "state road" (later the Nashville, Chattanooga, and St. Louis); and the Macon and Western (later to become the Central of Georgia).)

The suggestion of Augusta as the place for the convention, however, was not met with unanimous approval. In the March, 1849, issue of the *Southern Medical and Surgical Journal,* the Georgia Medical Society (in Savannah) made a suggestion for the meeting to be held in Macon on the 20th of March, since Macon was a more centrally located town. An article followed in one of the Savannah newspapers stating the change of time and place of the proposed meeting in Macon.

Accordingly, 75 physicians met in the Hall of Tomochichi Division, Sons of Temperance, in Macon on the morning of March 20, 1849, "in pursuance of a call from the Medical College of the State of Georgia and the Georgia Medical Society of Savannah."

The convention was organized by the election of temporary officers and the appointment of a committee to draft a Constitution and By-Laws for the permanent organization of a State Medical Society.

At the afternoon session, Dr. R. D. Arnold of Chatham County, chairman of the Constitution and Bylaws Committee, submitted its report which, with a few minor changes, was unanimously adopted. The group became "The Medical Society of the State of Georgia." The first president was Dr. Lewis D. Ford, of Augusta. Delegates were also named to the American Medical Association. Macon was chosen as the meeting place for the society the following year, and the date was changed to a day in April.

After the convention, 500 copies of a pamphlet containing the proceedings of the convention, the Constitution and By-Laws, and also a Code of Ethics were printed.

The gathering in Macon on April 20, 1850, was considered the first formal meeting of the Medical Society of the State of Georgia, but an accident on the Macon Railroad prevented some of the delegates from arriving in time and attendance was small.

The second meeting was held in Atlanta with 10 members present. At that meeting, 15 new members were elected. Members were requested to report to the Society the names of any persons practicing medicine in the state in violation of existing state laws. The names of 112 physicians were published as members. All "Auxiliary Societies," as county societies were then called, were invited to join the group.

In 1852, the Southwestern Medical Society of Georgia, the DeKalb Auxiliary Medical Society, and the Medical Society of Greene County were admitted.

The first meetings of the group were devoted mostly to elections and reading reports of committees, rather than discussing medical subjects. This was soon remedied by the establishment of a House of Delegates to take care of all matters of a medical and scientific nature. One of the first papers presented before the group was on "Health Statistics" and was based on data from the U.S. Census.

It was at the third meeting (in 1852) that Dr. Crawford W. Long, of Athens, read his paper on "Discovery of Anesthesia," which had been published in the *Southern Medical and Surgical Journal* in December of 1849, seven years after the discovery.

A resolution was also adopted to assess each member $2.00 to defray expenses of publication of Transactions, copies of which would be withheld from members who failed to remit their assessment.

In 1899, at the end of 50 years, the organization had 475 members. Its assets were $160.09.

The name of the society changed three times over the years and in 1873 became the Medical Association of Georgia. By the 1930s, a Headquarters had been established in Atlanta and the association was run almost entirely by a Secretary-Treasurer, who was usually an Atlanta physician. He also served as editor of the *Journal of the Medical Association of Georgia,* established in 1911.

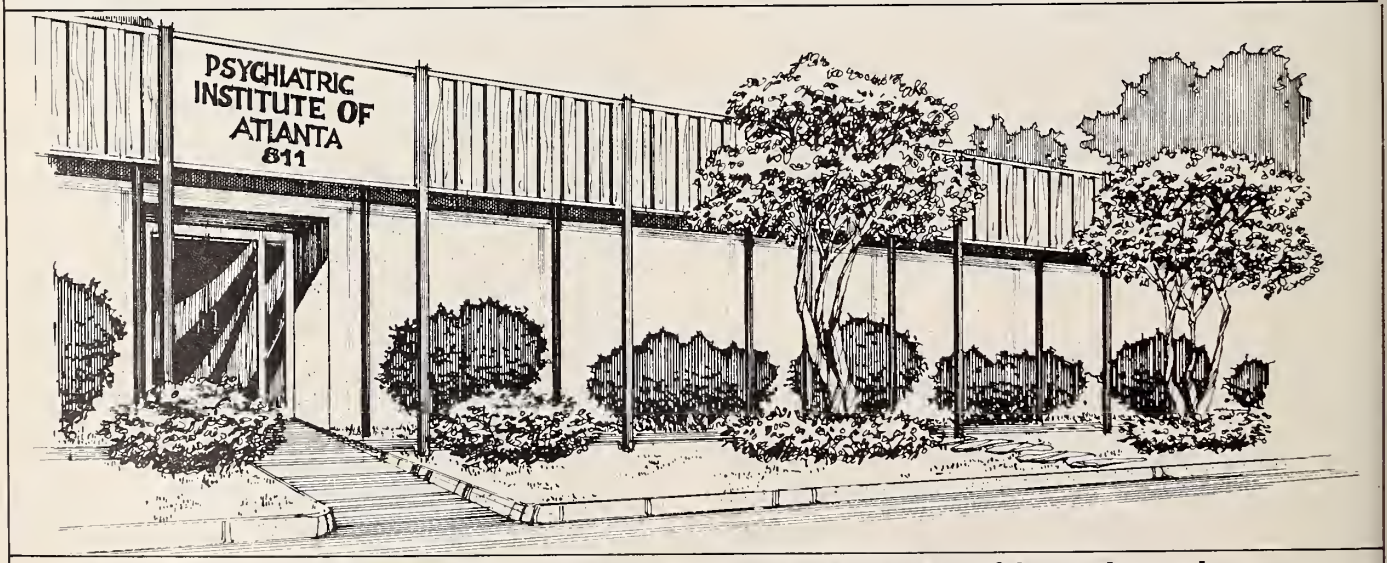
In April of 1949, a Centennial Issue of the *Journal* was published. There were then 2,202 members of the group.

In 1974, the Medical Association of Georgia celebrated its 125th anniversary in Savannah.

The current membership of MAG in 1982 is approximately 5,258.

(Prepared by Evelyn Gay (Mrs. Brit B., Jr.) of the Auxiliary to the Medical Association of Georgia, January 1982.)

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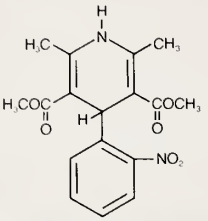
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Nifedipine is a yellow crystalline substance, practically insoluble in water but soluble in ethanol. It has a molecular weight of 346.3. PROCARDIA CAPSULES are formulated as soft gelatin capsules for oral administration each containing 10 mg nifedipine.

CLINICAL PHARMACOLOGY: PROCARDIA (nifedipine) is a calcium ion influx inhibitor (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac muscle and smooth muscle. The contractile processes of cardiac muscle and vascular smooth muscle are dependent upon the movement of extracellular calcium ions into these cells through specific ion channels. PROCARDIA selectively inhibits calcium ion influx across the cell membrane of cardiac muscle and vascular smooth muscle without changing serum calcium concentrations.

Mechanism of Action: The precise means by which this inhibition relieves angina has not been fully determined, but includes at least the following two mechanisms:

1) Relaxation and prevention of coronary artery spasm: PROCARDIA dilates the main coronary arteries and coronary arterioles, both in normal and ischemic regions, and is a potent inhibitor of coronary artery spasm, whether spontaneous or ergonovine-induced. This property increases myocardial oxygen delivery in patients with coronary artery spasm, and is responsible for the effectiveness of PROCARDIA in vasospastic (Prinzmetal's or variant) angina. Whether this effect plays any role in classical angina is not clear, but studies of exercise tolerance have not shown an increase in the maximum exercise rate-pressure product, a widely accepted measure of oxygen utilization. This suggests that, in general, relief of spasm or dilation of coronary arteries is not an important factor in classical angina.

2) Reduction of oxygen utilization: PROCARDIA regularly reduces arterial pressure at rest and at a given level of exercise by dilating peripheral arterioles and reducing the total peripheral resistance (afterload) against which the heart works. This unloading of the heart reduces myocardial energy consumption and oxygen requirements and probably accounts for the effectiveness of PROCARDIA in chronic stable angina.

Pharmacokinetics and Metabolism: PROCARDIA is rapidly and fully absorbed after oral administration. The drug is detectable in serum 10 minutes after oral administration, and peak blood levels occur in approximately 30 minutes. It is highly bound by serum proteins. PROCARDIA is extensively converted to inactive metabolites and approximately 80% of PROCARDIA and metabolites are eliminated via the kidneys. The half-life of nifedipine in plasma is approximately two hours. There is no information on the effects of renal or hepatic impairment on excretion or metabolism of PROCARDIA.

Hemodynamics: Like other slow channel blockers, PROCARDIA exerts a negative inotropic effect on isolated myocardial tissue. This is rarely, if ever, seen in intact animals or man, probably because of reflex responses to its vasodilating effects. In man, PROCARDIA causes decreased peripheral vascular resistance and a fall in systolic and diastolic pressure, usually modest (5–10 mm Hg systolic), but sometimes larger. There is usually a small increase in heart rate, a reflex response to vasodilation. Measurements of cardiac function in patients with normal ventricular function have generally found a small increase in cardiac index without major effects on ejection fraction, left ventricular end diastolic pressure (LVEDP) or volume (LVEDV). In patients with impaired ventricular function, most acute studies have shown some increase in ejection fraction and reduction in left ventricular filling pressure.

Electrophysiologic Effects: Although, like other members of its class, PROCARDIA decreases sinoatrial node function and atrioventricular conduction in isolated myocardial preparations, such effects have not been seen in studies in intact animals or in man. In formal electrophysiologic studies, predominantly in patients with normal conduction systems, PROCARDIA has had no tendency to prolong atrioventricular conduction, prolong sinus node recovery time, or slow sinus rate.

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure since severe hypotension can occur from the combined effects of the drugs. See Warnings.

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Increased Angina/Beta Blocker Withdrawal: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of PROCARDIA would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. See Warnings.

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: See Indications and Warnings. Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Carcinogenesis, mutagenesis, impairment of fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. In vivo mutagenicity studies were negative.

Pregnancy: Pregnancy category C. Nifedipine has been shown to be teratogenic in rats when given in doses 30 times the maximum recommended human dose. Nifedipine was embryotoxic (increased fetal resorptions, decreased fetal weight, increased stunted forms, increased fetal deaths, decreased neonatal survival) in rats, mice and rabbits at doses of from 3 to 10 times the maximum recommended human dose. In pregnant monkeys, doses 2/3 and twice the maximum recommended human dose resulted in small placentas and underdeveloped chorionic villi. In rats, doses three times the maximum human dose and higher caused prolongation of pregnancy. There are no adequate and well-controlled studies in pregnant women. PROCARDIA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

ADVERSE REACTIONS: In multiple-dose U.S. and foreign-controlled studies in which adverse reactions were reported spontaneously, adverse effects were frequent but generally not serious and rarely required discontinuation of therapy or dosage adjustment. Most were expected consequences of the vasodilator effects of PROCARDIA.

Adverse Effect	PROCARDIA (%) (N = 226)	Placebo (%) (N = 235)
Dizziness, light-headedness, giddiness	27	15
Flushing, heat sensation	25	8
Headache	23	20
Weakness	12	10
Nausea, heartburn	11	8
Muscle cramps, tremor	8	3
Peripheral edema	7	1
Nervousness, mood changes	7	4
Palpitation	7	5
Dyspnea, cough, wheezing	6	3
Nasal congestion, sore throat	6	8

There is also a large uncontrolled experience in over 2100 patients in the United States. Most of the patients had vasospastic or resistant angina pectoris, and about half had concomitant treatment with beta-adrenergic blocking agents. The most common adverse events were the same ones seen in the controlled trials, with dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

Several of these side effects appear to be dose related. Peripheral edema occurred in about one in 25 patients at doses less than 60 mg per day and in about one patient in eight at 120 mg per day or more. Transient hypotension, generally of mild to moderate severity and seldom requiring discontinuation of therapy, occurred in one of 50 patients at less than 60 mg per day and in one of 20 patients at 120 mg per day or more.

In addition, 2% or fewer of patients reported the following: Respiratory: Nasal and chest congestion, shortness of breath. Gastrointestinal: Diarrhea, constipation, cramps, flatulence. Musculoskeletal: Inflammation, joint stiffness, muscle cramps. CNS: Shakiness, nervousness, jitteriness, sleep disturbances, blurred vision, difficulties in balance. Other: Dermatitis, pruritus, urticaria, fever, sweating, chills, sexual difficulties.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

In a subgroup of over 1000 patients receiving PROCARDIA with concomitant beta blocker therapy, the pattern and incidence of adverse experiences was not different from that of the entire group of PROCARDIA treated patients (see Precautions).

In a subgroup of patients with a diagnosis of congestive heart failure as well as angina, dizziness or light-headedness, peripheral edema, headache or flushing each occurred in one in eight patients. Hypotension occurred in about one in 20 patients. Syncope occurred in approximately one patient in 250. Myocardial infarction or symptoms of congestive heart failure each occurred in about one patient in 15. Atrial or ventricular dysrhythmias each occurred in about one patient in 150.

Laboratory tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have already been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

OVERDOSAGE: Although there is no well documented experience with PROCARDIA overdosage, available data suggest that gross overdosage could result in excessive peripheral vasodilation with subsequent marked and probably prolonged systemic hypotension. Clinically significant hypotension due to PROCARDIA overdosage calls for active cardiovascular support including monitoring of cardiac and respiratory function, elevation of extremities, and attention to circulating fluid volume and urine output. A vasoconstrictor (such as norepinephrine) may be helpful in restoring vascular tone and blood pressure, provided that there is no contraindication to its use. Clearance of PROCARDIA would be expected to be prolonged in patients with impaired liver function. Since PROCARDIA is highly protein-bound, dialysis is not likely to be of benefit.

DOSAGE AND ADMINISTRATION: The dosage of PROCARDIA needed to suppress angina and that can be tolerated by the patient must be established by titration. Excessive doses can result in hypotension.

The starting dose is one 10 mg capsule, swallowed whole, 3 times/day. The usual effective dose range is 10–20 mg three times daily. Some patients, especially those with evidence of coronary artery spasm, respond only to higher doses, more frequent administration, or both. In such patients, doses of 20–30 mg three or four times daily may be effective. Doses above 120 mg daily are rarely necessary. More than 180 mg per day is not recommended.

In most cases, PROCARDIA titration should proceed over a 7–14 day period so that the physician can assess the response to each dose level and monitor the blood pressure before proceeding to higher doses.

If symptoms so warrant, titration may proceed more rapidly provided that the patient is assessed frequently. Based on the patient's physical activity level, attack frequency, and sublingual nitroglycerin consumption, the dose of PROCARDIA may be increased from 10 mg t.i.d. to 20 mg t.i.d. and then to 30 mg t.i.d. over a three-day period.

In hospitalized patients under close observation, the dose may be increased in 10 mg increments over four to six-hour periods as required to control pain and arrhythmias due to ischemia. A single dose should rarely exceed 30 mg.

No "rebound effect" has been observed upon discontinuation of PROCARDIA. However, if discontinuation of PROCARDIA is necessary, sound clinical practice suggests that the dosage should be decreased gradually with close physician supervision.

Co-Administration with Other Antianginal Drugs: Sublingual nitroglycerin may be taken as required for the control of acute manifestations of angina, particularly during PROCARDIA titration. See Precautions, Drug Interactions for information on co-administration of PROCARDIA with beta blockers or long-acting nitrates.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA Capsule contains 10 mg of nifedipine. PROCARDIA Capsules are supplied in amber glass bottles of 100 capsules (NDC 0069-2600-66).

The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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MEDICAL MEETING CALENDAR

MARCH

18—*Dalton:* **Genetics Inservice for Physicians and Health Professionals.** Category 1 credit. Contact Mae Johnson, RN, DHR NW Health District, Ste. AA, 111 Bryant's Crossway, Dalton. PH: 404/272-2342.

19—*Columbus:* **Carcinoma of the Breast, Ovary, and Endometrium.** Category 1 credit. Contact Shirley Preston, Amer. Cancer Society, 1422 W. Peachtree St., Atlanta 30309. PH:404/892-0026.

19-20—*Charleston, SC:* **16th Annual Ophthalmology Conference.** Category 1 credit. Contact Mary Lynn West, Med. Univ. of S.C., 171 Ashley Ave., Charleston, SC 29403. PH: 803/792-2492.

24-26—*Atlanta:* **Current Concepts in Pediatric Ophthalmology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta, 30322. PH:404/329-5696.

26-27—*Callaway Gardens:* **Geriatric Conference for Primary Care Physicians.** Category 1 credit. Contact Michael C. Sims, MD, Dept. of Fam. Pract., P.O. Box 7216, Columbus 31908-7216. PH:404/571-1133.

28-31—*Charleston, SC:* **The Aging Ovary.** Category 1 credit. Contact William C. Wilson, MD, Med. Univ. of S.C., 171 Ashley Ave., Charleston, SC 29403. PH:803/792-2864.

APRIL

1—*Savannah:* **AMA "Giving Your Practice A Check-Up" Seminar for Physicians.** Contact CaRita Connor, GA Med. Society, P.O. Box 1703, Savannah 31401. PH:912/355-6607.

2—*Atlanta:* **AMA "Gearing Up for Retirement" Seminar for Physicians.** Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in Ga.).

1-3—*Atlanta:* **Emory Medical Alumni Conference.** Contact Alumni Office, Emory Univ., Atlanta 30322. PH:404/329-6199.

2-4—*Atlanta:* **Second Annual Atlanta Eye Congress.** Category 1 credit. Contact Ms. Ginger Lineberger, 3280 Howell Mill Rd., NW, Ste. 207, Atlanta 30327. PH:404/351-2713.

4-7—*Atlanta:* **Atlanta Graduate Medical Assembly.** Category 1 credit. Contact Wynnell S. Hopkins, 875 W. Peachtree St., NE, Atlanta 30309. PH:404/881-2168.

5-7—*Atlanta:* **Pediatrics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Atlanta:* **"Starting Your Practice" Seminar for Residents.** Cosponsored by AMA & MAG. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224.

15-17—*Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

15-17—*Atlanta:* **Pediatric Hematology/Oncology for the 80's.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

17-18—*Atlanta:* **Hemodynamic Monitoring.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

20-24—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-24—*Atlanta:* **Arrhythmias and Cardiac Ischemia: Diagnosis and Management.** Category 1 and AAFP prescribed credit. Contact International Med. Ed. Corp., 64 Inverness Dr., East, Englewood, Colo. 80112. PH:800/525-8651.

24-25—*Augusta:* **Disease Prevention and Health Maintenance.** AMA Category 1 and AAFP prescribed credit. Contact Gerald T. Chambers, Ph.D., Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

25-29—*Atlanta:* **31st Annual Scientific Session — American College of Cardiology.** Contact Meeting Services Dept., ACC, 9111 Old Georgetown Rd., Bethesda, MD 20814. PH:301/897-5400.

30-May 1-2—*Myrtle Beach, SC:* **Third National Conference on Emotional Stress and Cardiovascular Disease.** Category 1 credit. Contact Charles D. Troutman, Am. Heart Assn., S.C. Affil., P.O. Box 6604, Columbia, SC 29260. PH:803/738-9540.

MAY

3-8—*Augusta:* **17th Annual Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

13-14—*Atlanta:* **Fifth Annual Course on Management of the Chronic Renal Disease Patient.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

13-15—*Atlanta:* **Annual Update in Pathology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

17-19—*Atlanta:* **Coronary Disease-1982.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-21—*Atlanta:* **Eighth Annual Course on Technique in Orthopaedic Surgery: Deformities of the Spine.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

20-21—*Callaway Gardens:* **Tenth Annual Perinatal Medicine Conference.** Category 1 credit and AAFP prescribed credit. Contact Micki L. Souma, MD, Chief Dept. OB/GYN. Med. Ctr., P.O. Box 951, Columbus 31902. PH:404/324-4711.

21-22—*Atlanta:* **Update of Systemic Lupus Erythematosus: Current Concepts of Diagnosis and Treatment.** Category 1 credit. Contact Karen Crenshaw, West Paces Ferry Hosp., 3200 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-0351 x208.

JUNE

3-5—*Atlanta:* **Clinical Topics in Gynecology & Obstetrics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta, 30322. PH:404/329-5696.

4-11—*Mississippi River Cruise:* **Cardiology for the Practitioner.** Category 1 credit. Contact Univ. of Fla. College of Med., Box J233, JHM Health Ctr., Gainesville, FL 32610. PH:904/392-3143.

14-16—*Kiawah Island, SC:* **Recent Advances in Internal Medicine.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.



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JOURNAL
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Use of the Glycosylated Hemoglobin (HbA_{1c}) Test to Monitor Diabetic Control

THOMAS C. JONES, M.D., *Macon**

Abstract

A normal or markedly elevated level of HbA_{1c} would suggest either adequate or inadequate diabetic control over a period of 4-6 weeks; however, a moderately elevated level would lead to speculation about prior diabetic control. The HbA_{1c} test is the only available laboratory test objectively providing an assessment of prior diabetic control. The test should only be ordered, however, if glucose determinations and physician-patient assessments cannot accurately obtain the same information.

For several years, the American Diabetes Association has recommended that physicians maintain optimal regulation of their patients' glucose levels in order to prevent the complications of diabetes mellitus.[1] Even though physicians obtain plasma glucose determinations or quantitative urine glucose samplings, they are not always able to ascertain if their diabetic patients have been "in control," primarily because these tests reflect only finite periods of time. Consequently, more physicians are currently employing the hemoglobin A_{1c} (HbA_{1c}) test to determine and evaluate "prior glucose control."

HbA_{1c} is the most commonly occurring minor hemoglobin, accounting for 4-6% of the total hemoglobin. It is structurally related and derived from hemoglobin A (HbA) by the addition of a molecule of glucose to the N-terminal of the beta chain. The biosynthesis of HbA_{1c} first requires the formation of an unstable Schiff base (pre-A_{1c}) which then slowly forms HbA_{1c}, a more stable compound (Figure 1). Because of the addition of the glucose molecule, both of these hemoglobins are defined as glycosylated and are collectively measured and recorded as HbA_{1c}. It should be noted that commercial laboratories do not routinely separate these compounds.

Questions of Reliability

Several studies have revealed that the formation of HbA_{1c} is a nonenzymatic, post-translational modification of HbA that is irreversible and that its formation is directly related to the glucose concentration in the blood.[2, 3] This irreversibility suggested that the level of HbA_{1c} reflected glycemic control for

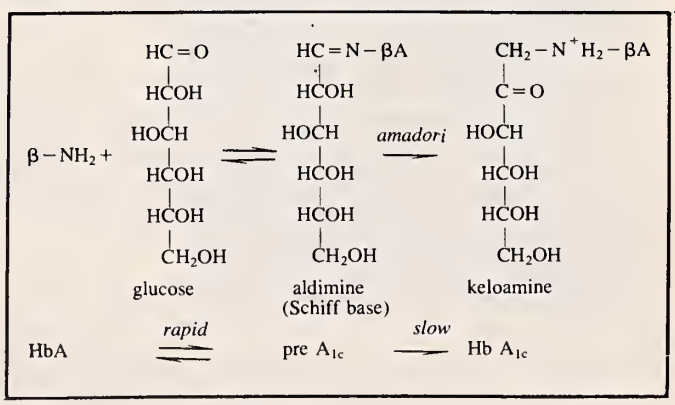


Figure 1 — Reaction Pathway for the Synthesis of Hemoglobin[13]

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TABLE 1 — Comparative Commercial Laboratory Testing to Determine Hemoglobin A_{1c}

Laboratory	HbA_{1c} (%) Normal	Fair Control	Poor Control
Metpath	2—7.5	7.6—8.9	>9
Biomedical Reference lab	5.8—8.8		
BioScience	6.0—8.8		
P S P A	5.5—8.5		> 9.5
UpJohn	6—9		

Method: Cation exchange liquid chromatography; these data determined as of June, 1981.

the preceding life span of the red blood cell, i.e., for 120 days. However, Koenig and his colleagues[4] concluded that the assessment of glycemic levels could be evaluated by this test for *only* the preceding 4-6 weeks.

In another study, Service et al.[5] revealed that the level of HbA_{1c} may actually change by as much as 2% within a few hours or days as metabolic control is attained in uncontrolled diabetics. The reason for this rapid change in the concentraiton of HbA_{1c} has been attributed to the laboratory measurement of not only HbA_{1c} but also the rapidly reversible pre-A_{1c}.[6] Several other studies have confirmed the rapid fluctuation of the HbA_{1c} level with correction of hyperglycemia or induction of hyperglycemia within a period of a few hours to several days.[7, 8] Thus, these studies raise several doubts regarding the usefulness of the hemoglobin A_{1c} test for monitoring diabetic control. Bunn,[9] however, has shown that in stable diabetics, the pre-A_{1c} level will not interfere with HbA_{1c} measurements even if there is a rapid change in glucose levels just preceding the measurement of HbA_{1c}. On the contrary, he states that an unstable diabetic may have rapid fluctuations in the HbA_{1c} level due to rapid fluctuations in the pre-A_{1c} level.

Gohen and his colleagues[10] reported a direct correlation between physicians' ratings of the degree of control of their diabetic patients and the level of HbA_{1c}. Those patients rated as having "poor control" of their diabetes had elevated HbA_{1c} levels.

Questions of Relevancy

Many physicians have been using this new laboratory test for assessment of their patients' control because of its availability through several commercial laboratories and its estimation of metabolic control over the preceding weeks.

Considering the above controversies, what, then, is the place for this new and expensive laboratory test that is supposed to improve the physician's monitoring of his diabetic patients? If a physician feels that his patient is in good control, a "fasting" and "2-hour post-prandial" blood sugar would be adequate follow up instead of obtaining an HbA_{1c} level which would probably be normal. Likewise, there would be no reason to order an HbA_{1c} level on chronically uncontrolled patients whose blood sugars remain persistently elevated. In some instances, however, physicians could use the results of the HbA_{1c} test to substantiate their assessment of poor metabolic control in patients who adamantly insist that they are in good control.

In addition, the HbA_{1c} level has been useful in assessing the risk of major congenital malformations, because a higher incidence of congenital malformations has occurred in pregnant diabetic women with higher levels of HbA_{1c}. Women with diabetes who want to become pregnant should monitor basal body temperatures and remain in excellent control. Most of these patients' pregnancies are diagnosed 8-12 weeks after conception. Unfortunately, the incidence of fetal anomalies occurring in pregnant diabetic patients appears to be related to the control of glucose levels during the first 8 weeks after conception.[11] Sometimes, the obstetrician may not be aware of his/her patient's diabetic condition, and this test, therefore, might give him/her some knowledge of prior control and also influence the future management of the case. As stated above, fluctuations in the HbA_{1c} concentration might occur and, for this reason, a physician should not rely solely on one laboratory test when assessing a metabolic condition.

In some instances, physicians have recommended the HbA_{1c} test for diagnosing diabetes rather than employing the glucose tolerance test. I feel that both tests, if accurately performed, may provide that information, but from a "fasting" and "2-hour postprandial" blood sugar, the physician can derive the same diagnosis and at a lower cost to the patient. Because of the rising cost of medical care, physicians need to evaluate cost effective ways of diagnosing and monitoring patients with chronic diseases.

Back to Basics

The monitoring of a chronic disease such as diabetes should be the ultimate responsibility of the patient. *Take Charge of Your Diabetes,*[12] the title of Dr. C. M. Peterson's book, conveys this message. With proper education, the diabetic patient should be able to control his/her disease. Each patient must understand the pathophysiology of the disease, learn ways to monitor it, and be aware of its complications if control is not maintained. It is the responsibility of the physician to teach his/her patients to treat and monitor their disease with medical supervision. Thus, maintaining records of home glucose monitoring appears to be the only reliable way for both the patient and physician to be able to monitor diabetic

control on a daily basis to prevent the complications of this chronic disease.

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The author describes a study in which patients who were made more aware of the specific details of treatment gained a more positive attitude about their disease.

The Psychologic Consequences of Blood Glucose Self-Monitoring in the Treatment of Diabetes

MORTON D. BOGDONOFF, M.D., *New York**

DIABETES MELLITUS is a prime example of a chronic, irreversible disease with which patients must learn to cope. The need to balance the normal independence of being well with the constant dependence upon treatment often results in major psychologic problems, particularly for those patients with the insulin-dependent type of the disease. Behavioral responses range from overwhelming preoccupation with the disease to denial and disregard, though many patients manage to effect a satisfactory balance.

Emotional Impact of the Disease

The emotional difficulties of diabetic patients has received considerable attention in the medical literature. Most reports are anecdotal summaries which portray extraordinary distress.[1, 2] The more rigorously structured assessments of psychologic status, though not as alarming, do report a high incidence of anxiety and depression and indicate that the magnitude of depression and anxiety may be related to the adequacy of control of the hyperglycemia.[3, 4] Many patients find the demands of treatment too burdensome. In addition, the vagaries and vicissitudes of daily life — success or failure in school, happenings at work, trials and tribulations of children and friends, the usual despairs and difficulties that exist in all families — may exert an amplified impact upon the nature of the control of the diabetes. It has become an axiom of optimal diabetic care that the emotional components of a patient's life may both affect and be affected by the control of the disease.[5]

* Dr. Bogdonoff is Professor of Medicine, Cornell University Medical College, 1300 York Ave., New York, NY 10021. Address reprint requests to him. This paper was presented in part at a symposium at Rockefeller University in New York City, Dec. 17, 1980.

Self-Monitoring of Blood Glucose

Based upon prior experience, a procedure designed to more closely regulate the extent of blood glucose variability might be expected to have two salutary consequences: first, an enhanced awareness by the patient of the specific details of treatment, and, second, as the disease management changes, there would be significant alteration in patient attitudes.[6] Therefore, a priori, one might expect both a cognitive and affective change in patients placed on a program of rigorous self-monitoring of blood glucose.

The Rockefeller University Study

The psychologic consequences of self-monitoring of blood glucose have been observed by a number of physicians.[7] One focused and systematic study was reported from Rockefeller University,[8] and the results are of sufficient interest to warrant summarizing in some detail. The study involved a group of 10 insulin-dependent diabetic patients, seven women and three men, ranging in age from 15 to 36 years. Most were in the lower-middle socioeconomic group. The average duration of the disease had been 10 years. Four of the patients had proliferative retinal disease, two had received photocoagulation, and eight had peripheral neuropathy determined by physical examination and/or nerve conduction studies. Four patients had at one time received psychiatric care for emotional disturbance related to their

diabetes; two of them were receiving psychotherapy at the time of their first visit.

The self-monitoring blood glucose program emphasized mealtime glucose bracketing (a blood glucose value before and 1 hour after each meal). Hemoglobin A_{1c} levels were measured at monthly intervals as an indication of overall blood glucose modification.

At the outset of the study, each patient was seen for a 1-hour, semi-structured psychiatric interview and rated for depression on a 19-item scale which included such symptoms as anxiety, hypochondriasis, helplessness, and hopelessness. This scale had been previously correlated with the character of illness in a series of patients with varying degrees of clinical depression.[9] Each of the items was rated from 0-4, and the sum of all 19 items constituted the total rating. A score of 10 was associated with mild to moderate depression, while a score of more than 20 was indicative of severe depression. At the end of the study, another structured interview and depression scale rating were conducted. At both interviews, the interviewer was unaware of either how well the patient had controlled the level of blood glucose or of the hemoglobin A_{1c} levels.

At the initial interview, the major feature of the patient's affect was one of severe depression, with feelings of guilt, self-reproach, and preoccupation with the recognized difficulty in managing the diabetes. Several of the patients reported feeling helpless and hopeless and attributed their problems to ineffectual and incompetent medical care. There were frequent histories of eating binges and intermittent carelessness about the diabetic regimen.

At the outset of the study, the rating scales ranged from 7 to 36, with a mean level of 20.7 (seven of the patients had scores of 16 or more). The hemoglobin A_{1c} level at the outset ranged from 6.5% to 15%, with a mean of 10.3% (normal, 3-6%).

At the end of 8 months, the clinical interview data changed dramatically. There was a striking increase in the ability of patients to achieve better glucose control, and they reported a sense of pride in this. They had all become enthusiastic proponents of the frequent blood sampling technique. Self-reproach was no longer present, and anxiety, depression, and preoccupation were lessened. Two patients who had been unemployed had started back to work, and they attributed this to the improvement in their diabetic control.

The depression rating scale decreased sharply, to a range of 2 to 22, with six of the patients having a 7 or less. The mean for the group was 10.2, a score which has a probability of less than .005 when a paired comparison T test is performed. In addition, the hemoglobin A_{1c} values dropped to a range of 3.5% to 9.4%, with a mean of 5.4%.

When a rank-order comparison was made between the level of the depression scale and the hemoglobin A_{1c} value, there was a striking correlation at the outset of the study. After 8 months, however, there was no such rank-order correlation. This may have been due to the fact that only two patients had abnormally elevated hemoglobin A_{1c} values (6.9% and 9.4%), and only four patients had scale values above 10. Thus, there was no longer a broad enough spread of data to permit a rank-order correlation. For all intents and purposes, six of the 10 patients no longer had clinically significant depression ratings, and eight of the 10 had normal hemoglobin A_{1c} values.

The patients reported little difficulty in obtaining blood samples but did report some emotional discomfort when using the instrument in the presence of colleagues or supervisors at work. They attributed this to concern about being unfavorably viewed as "limited" or "handicapped."

Conclusions

The issue of the psychologic aspects of blood glucose control is clearly an important factor in treating diabetes. The role of home glucose monitoring in achieving control, without undue preoccupation with the disease, certainly merits further investigation. From these observations, there appear to be no negative consequences about which patients and physicians should be concerned. Being more involved in the precise details of one's diabetic regulation appears not to be viewed as an additional burden, but rather as an opportunity to more effectively control the disease.

Summary

The balance between the desire to be well and independent and the need to remain aware of one's illness may be most successfully accomplished by including an extremely accurate index, as is provided by frequent self-monitoring of blood glucose in the treatment regimen. More dependence on a specific procedure may well result in more effective individual independence, and this may lead to a more emotionally satisfied patient. To date, the Rockefeller University study would certainly warrant further follow up.

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SU-TON®

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A Tonic for Geriatric Patients

A pleasant tasting tonic containing iron, vitamins, minerals, and an analeptic. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

DESCRIPTION Forty-five milliliters of SU-TON contains the following ingredients: Pentylenetetrazol, 30 mg • Niacin, 50 mg • Vitamin B-1, 10 mg • Vitamin B-2, 5 mg • Vitamin B-6, 1 mg • Vitamin B-12, 3 mcg • Manganese (as Manganese Sulfate), 1 mg • Magnesium (as Magnesium Sulfate), 2 mg • Zinc (as Zinc Sulfate), 1 mg • Iron (as Ferric Pyrophosphate, Soluble), 22 mg • Alcohol, 18%

INDICATIONS AND USAGE SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium; the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE Drug dependence has not been reported with SU-TON.

OVERDOSAGE Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage. Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION One tablespoonful (15 ml) 3 times a day 20–30 minutes before meals. This drug is not for use in children under 12 years of age

HOW SUPPLIED Bottles of 473 ml (16 fl. oz.) NDC 0524-1015-16

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Pentylenetetrazol	25.0 mg
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Nicotinic acid	50.0 mg

Clinically proven actions

- Antihistaminic
- Cerebral stimulant
- Vasodilator

Few side effects

- Vasodilation occasionally causes facial flushing which can be minimized by recommending that Ru-Vert® be taken following meals or with food.

Dosage

- One or two tablets three times a day

Please see next page for a summary of prescribing information

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In Vertigo
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RU-VERT®

See following prescribing information.

DESCRIPTION: Each tablet contains the following active ingredients:

Pentylenetetrazol	25.0 mg
Pheniramine maleate	12.5 mg
Nicotinic acid	50.0 mg

INDICATIONS: Ru-Vert is indicated as an adjunct therapy in the symptomatic treatment of acute or chronic vertigo.

CONTRAINDICATIONS: Convulsive disorders or known history of sensitivity to any of the listed active ingredients. Because of the vasodilating action of nicotinic acid, Ru-Vert should not be used in patients with hypotension.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with Ru-Vert.

OVERDOSAGE: Signs and symptoms of acute overdose may be due primarily from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION: The recommended dosage of Ru-Vert for vertigo or motion sickness is 1 or 2 tablets three times a day with meals or light snacks.

This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 100 tablets	NDC 0524-0060-01
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The author describes and explains the numerous advantages of the portable infusion pump, particularly the battery-powered one.

Effecting Better Insulin Control With the Portable Infusion Pump

JOSEPH W. DeHAVEN, M.D., *Savannah**

THE DISCOVERY of insulin has dramatically increased the life expectancy of diabetic patients. However, conventional insulin treatment has failed to normalize the diabetic patients' life expectancy, and these patients continue to die of the complications of the disease. This is perhaps related to the failure of conventional insulin regimens to truly achieve euglycemia. For example, during any 24-hour period, patients with juvenile onset diabetes, when managed with conventional insulin regimens, often have blood glucose levels in excess of 200 mg/dl, or lower than 50mg/dl, or both. Most diabetologists now believe that the complications of diabetes are a direct consequence of poor glucose control, rather than a separately inherited part of the diabetic syndrome.[1] Implicit in this belief is that if euglycemia could be achieved in the diabetic patient, then complications of the disease could be prevented.

Mechanical Infusion Pumps — Advantages and Disadvantages

Diabetes research has recently been aimed at finding new methods of insulin delivery in order to provide insulin in closer accordance with physiologic needs. The recent use of mechanical infusion pumps has been a significant step toward achieving this goal. Such mechanical devices have been classified into closed-loop and open-loop systems. The closed-loop system was developed several years ago by researchers in Toronto.[2] This system consists of a glucose sensor which continually monitors a patient's blood glucose, a computer which constantly analyses these blood glucose levels, and a pump which infuses insulin based on the computer's interpretation of the blood glucose values. Although the system has been able to achieve euglycemia in patients for as long as 48-72 hours, several drawbacks have limited its use to the research laboratory. First, the system requires constant intravenous access, posing the risk of phlebitis and infection. Second, the glucose sensor has not been adequately miniaturized to make the system a practical tool.

The drawbacks of the closed-loop method were overcome when researchers from England and Yale University designed a system which eliminated the intrinsic glucose sensor.[3-7] This method of insulin delivery is called the open-loop system, since the patient monitors his own blood glucose and is able to change the insulin delivery accordingly.

The Battery-Powered Pump — Distinct Advantages

A portable, battery-powered infusion pump was first used clinically to deliver desferroxamine to prevent iron overload in patients with thalassemia. This pump was then used in the initial trials of delivering insulin to diabetic patients.

The most recently designed pump weighs approximately 10 ounces, measures 6″ by 3″, and is worn on a patient's belt or is carried in a pocket. It is powered by a rechargeable battery and contains a syringe which the patient fills with diluted, regular insulin. The syringe is connected to a 42″ plastic catheter with a 27-gauge needle. The patient inserts the needle subcutaneously in the lower abdomen or thigh and tapes the needle in place. A small amount of antimicrobial ointment is placed at the site of entry to

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prevent local infection. The pump slowly advances the plunger of the syringe, and delivers a small (.005-.4 cc) bolus of insulin subcutaneously every 4 to 30 minutes. This provides the patient with a basal infusion of insulin similar to the manner in which it would be delivered by a normal pancreas. Once the needle is in place, the patient is usually unaware of its presence. The needle is usually changed every 4 days.

The dosage of insulin is partially based on body weight. At the time of a brief hospitalization, the patient is trained in how to use the pump, and a precise dosage is established. Patients are instructed to measure their own blood glucose levels prior to meals, using a home glucose monitor. This method entails obtaining capillary blood by finger stick, placing it on a reagent strip, and inserting this into a small, simple machine. This provides the value of the blood glucose using a reflectance meter system. The patient then decides on a dosage of regular insulin to "cover" the ensuing meal. Once this is determined, the patient then pushes a button on the pump which temporarily speeds delivery and provides the supplemental dose, which is indicated on the digital display. The pump thus provides insulin in a pseudo physiologic way. Although this dosage determination is somewhat arbitrary, the patient soon learns the proper amount necessary to achieve euglycemia. Patients are able to modify their dosage at times of changing insulin needs, such as during infections or stress, by "dialing in" more or less insulin.

Preliminary evidence indicates that achieving euglycemia by using the insulin infusion pump normalizes some other hormonal and metabolic abnormalities associated with diabetes.

Mechanical problems thus far have been rare, and patients are able to detect failure by observing a rise in their blood glucose. Experiments in turning off the pumps have shown a significant blood glucose rise to 200-400mg/dl after approximately 12 hours. Once the pumps were re-started, euglycemia was achieved in about 4 hours. Recently developed pumps also have a warning light to indicate mechanical failure.

Patients have generally been able to maintain their usual lifestyles. Of the 20 patients now using the pump in my practice, only one woman found it cosmetically unacceptable enough to discontinue its use. Patients have been able to jog, play racquet ball, and continue all their usual sports activities. One teenager continues to play high school football, simply by taking the pump off following his pre-lunch insulin dosage, attending practice in the afternoon, and restarting the pump prior to his evening meal. When showering or bathing, the patient can remove the tubing from the pump, and place a cap at the end. When sleeping, some patients prefer to place the pump on a bedside table, while others feel more comfortable sleeping with it attached to a loosely fitting belt.

Chemical Advantages of the Pump vs. Conventional Therapy

Initial studies by Tamborlane et al. at Yale University indicated that this system of insulin delivery could indeed achieve better glucose control than conventional therapy on an inpatient basis.[6] In their studies, mean 24-hour plasma glucose levels ranged from 132-330mg/dl in patients prior to pump therapy. During pump infusion, plasma glucose levels fell dramatically to a mean value between 79-99mg/dl. Not only were plasma glucose levels reduced, but fluctuations in glucose levels also dramatically decreased. The maximal excursion in plasma glucose during pump infusion was 54-131mg/dl less than that observed during pre-infusion conventional therapy.

These investigators extended their studies to address the question of whether achieving euglycemia by using the pump would also normalize other hormonal and metabolic abnormalities associated with diabetes. They found that serum cholesterol and triglycerides fell below conventional treatment levels by 17% and 60%, respectively.[8] Additionally, with conventional insulin treatment, hyperaminoacidemia, which reflects a defect in the body's ability to replete muscle nitrogen, was normalized after pump treatment. Mineral metabolism has been found to be altered in diabetics who are treated by conventional therapy, in that they have relative hypercalciuria, hyperphosphaturia, and a higher incidence of osteopenia. Such abnormalities were reversed 7-14 days after initiation of pump infusion.[9] Finally, it is well known that diabetics on conventional therapy have high fasting growth hormone levels, low somatomedin levels, and an exaggerated growth hormone response to exercise. These metabolic abnormalities have also been reversed with pump therapy.[10]

Unanswered Questions Regarding Diabetic Therapy

The question of whether complications of diabetes, once present, can be reversed with the attainment of euglycemia remains unanswered. There is preliminary evidence, however, that diabetic peripheral neuropathy, if detected early, can be reversed by the attainment of euglycemia. Abnormal median and peroneal nerve conduction found in con-

ventionally treated diabetic patients was partially reversed with pump therapy.[11] Preliminary studies on abnormal renal function have shown no improvement in proteinuria or creatinine clearance. In a small group of diabetic patients with subnormal creatinine clearances, however, who were followed for 1 year on pump therapy, no further deterioration of renal function was demonstrated.[12] It has generally been observed that once significant nephropathy develops in a person with diabetes, there is a slow but steady linear decline in renal function. If further studies support these initial observations, achieving euglycemia with the portable infusion pump may halt the progression of diabetic nephropathy.

Another important question to be answered is whether improved blood glucose regulation using insulin infusion systems is secondary to the physiologic pattern of insulin delivery or to the enhanced enthusiasm of the investigators. Early studies by Wahren and Sacca[13, 14] suggest that the excellent blood glucose control achieved with the pump may be due to the provision of insulin as a basal infusion. This method of insulin delivery allows the liver to function more normally in glucose homeostasis, preventing wide swings in blood glucose. Another study suggests, however, that during short inpatient observations, manipulations of intensive conventional therapy achieves as good blood glucose regulation as the insulin infusion pump.[15] Several outpatient studies are presently in progress comparing intensive conventional therapy with the insulin infusion system.

Other directions of research include the investigation of implantable miniaturized infusion pumps, and implantable polymer pellets impregnated with insulin.[16, 17] These advances will hopefully allow us to achieve better blood glucose control in diabetics and prevent or retard long-term complications of the disease.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
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Update on Nutrition Therapy for Diabetes

HOPE WARSHAW, R.D., M.M. Sc. *Atlanta**

SINCE 1922, when insulin was first prescribed in the treatment of diabetes, many changes have been instituted in the nutrition therapy of diabetic patients. This article will cover some basic principles of diet therapy as well as discuss some current issues.

Principles of Nutrition Therapy for Diabetes

It is important to differentiate between the basic concepts of diet therapy in the two classes of diabetes, insulin-dependent diabetes mellitus (IDDM), referred to as Type I, and non-insulin-dependent diabetes mellitus (NIDDM), referred to as Type II. These differences are described in Table I.[1] After insulin was initiated as the panacea for diabetes control, diet therapy received less attention. In the last decade, however, health care providers have become increasingly aware of the important role that diet plays in the insulin-diet-exercise triangle of diabetes control. The results of the University Group Diabetes Program (UGDP) in 1974 further increased the attention given to diet as an effective component of control.

Approximately 80% of those with Type II, NIDDM, diabetes are obese. Therefore, the treatment is diet therapy alone. Hypocaloric diets with resultant weight loss achieve normoglycemia in most patients. Research in the past 10-15 years has revealed that NIDDM is not a disease of insulin deficiency; it is a disease of insulin excess with an inability of the body to properly use endogenous insulin. Weight loss in the obese individual with diabetes increases the receptor site number and increases the body's sensitivity to endogenous insulin. Exogenous insulin is not of long-term benefit to these individuals.

Exogenous insulin is a necessity in IDDM. Diet therapy is used to aid in the control of glycemia.

In NIDDM, the goal of diet therapy is to restrict caloric intake with resultant weight loss, while the primary goal in IDDM is to balance nutrient intake. An additional objective of diet therapy in IDDM is to help the patient develop a consistency in the timing of meals and snacks with regard to their insulin injections.

In 1979, the American Dietetic and Diabetic Associations collaborated in publishing *The Principles of Nutrition and Dietary Recommendations for Individuals with Diabetes*. This publication outlines the current thoughts on the distribution of carbohydrate, protein, and fat components in the diet for diabetes.[2] The greatest change is the recommendation that 50-60% of the caloric intake be from carbohydrates. Individuals are encouraged to select from carbohydrate foods (such as whole grain products, fresh fruits, and raw vegetables) that provide increased quantities of dietary fiber.

The protein portion of the diet should contribute 12-20% of the total caloric intake. Note that this is slightly lower than the protein intake in the average American diet. Minimizing the intake of animal protein decreases the quantity of saturated fat and cholesterol in the diet.

Fat, the final component of the diet, should contribute approximately 30% of the total calories consumed. Saturated fat should be limited to 10%, and polyunsaturated fat should contribute at least 10% of the total fat intake. The remaining 10% should be derived from monosaturated fat.

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TABLE 1 — Dietary Strategies for the Two Main Types of Diabetes[1]

Dietary Strategy	Obese patients not requiring insulin	Insulin dependent non-obese patients
Decrease calories	Yes	No
Protect or improve Beta cell function	Very urgent priority	Seldom important
Increase frequency and number of feedings	Usually no	Yes
Day to day consistency of calories, carbohydrate, protein, and fat	Not crucial if average calorie intake remains in low range	Very important
Consistency in timing meals	Not crucial	Very important
Extra food for unusual exercise	Usually not appropriate	Usually appropriate
Use of food to treat, abort, or prevent hypoglycemia	Not necessary	Important
During complicating illness provide small frequent feedings of carbohydrate to prevent starvation ketosis	Often not necessary because of resistance to ketosis	Important

The recommendations in the above-mentioned publication are comparable to the dietary goals established for the United States population in general as documented in the U.S. Surgeon General's 1979 report on health promotion and disease prevention entitled "Healthy People."[3] The vitamin and mineral requirements for individuals with diabetes also do not differ from the needs of the general population set forth by the National Research Council as the Recommended Daily Allowances (RDA).[4] It should be noted, however, that if individuals are on a hypocaloric diet below 1000 to 1200 calories, vitamin and mineral intake should be supplemented.[2]

In non-insulin-dependent diabetes mellitus, the goal of diet therapy is to restrict caloric intake with resultant weight loss, while the primary goal in insulin-dependent diabetes is to balance nutrient intake.

The primary educational tool used to teach people with diabetes how to understand their diet is the exchange system developed in 1950 by the American Dietetic and Diabetes Associations.[5] The exchange system divides all foods allowed in the diabetic diet into six food groups. Each food group contains an approximate number of calories and grams of carbohydrate, protein, and fat. These figures are used for diet calculations. The exchange system was revised in 1976, with the major revision being in the amount of cholesterol, saturated fat, and total fat in the diet. As of 1976, the exchange system promotes the consumption of skim milk, low fat meats, and polyunsaturated fats to help decrease one risk factor indicated in cardiovascular disease.

When using the exchange system, the important point to remember is the necessity to individualize each patient's diet. It is essential to provide the patient with a regimen that he/she is able to follow, one which considers ethnic backgrounds, previous dietary habits, and daily routines.

Another essential key to the success of nutrition therapy is the ability to provide follow-up care for the patient. It would be a little premature to assume that the patient will adopt a new lifestyle after minimal instruction. In this respect, a dietitian/nutritionist can be a valuable teaching component of any physician's effort to help a patient control their disease.

Current Issues in Nutrition Therapy: Diabetes and Fiber

Recently, it has been noted that the inclusion of fiber in the American diet has drastically decreased, since more foods are now refined.[6, 7] The reduction of the fiber portion of our diets has been correlated with the increased rate of certain degenerative diseases such as diabetes.[8]

There are basically two types of fiber found in the diet, soluble and insoluble. The soluble fibers, like quar gum and pectin, form gels in the gut that delay gastric emptying and therefore impair nutrient absorption. The insoluble fiber, such as whole grains, cereals, and vegetable products, impair nutrient absorption by increasing the transit rate of foods through the gastrointestinal tract. They also increase fecal bulk.[9]

A beneficial effect of glycemic control has been documented as a result of increased fiber intake. Studies show decreased plasma glucose values occurring with both soluble[10] and insoluble[11] fibers. An additional benefit, as reported by Anderson,[12] is a decrease in the requirement for exogenous insulin by patients with IDDM.

It is worthwhile to advise individuals with diabetes to increase their intake of dietary fiber to improve their general health and to possibly de-

crease glycemia. Increasing the fiber in the diet can be achieved by simply eating more whole grain products, fresh fruit, and raw vegetables. Anderson[13] further suggests that the optimal intake of fiber per day is 20-25g per 1000 calories. Table 2 provides a list of the dietary fiber content of several common foods.

TABLE 2 — Dietary Fiber Content of Common Foods[14]

Product	Common Portion	Total Dietary Fiber (g)
Beans, string	½ cup	3.4
Beans, lima	½ cup	3.7
Lettuce	½ cup	1.5
Apple	1 small	3.4
Banana	½ small	1.8
Orange	1 small	2.1
Bread, whole wheat	1 slice	9.5
Bread, white	1 slice	2.7
Rice, brown	½ cup	5.5
Wheat, shredded	1 serving	12.2

Diabetes and Alcohol

A frequent question is whether or not to include alcohol in the diet of the diabetic patient. Again, it is important to differentiate between the two types. Alcohol should not be included in the diet of the obese person with diabetes as it provides 7 calories per gram (i.e. 1 ½ ounces of gin = 107 calories). The calories derived from alcohol provide essentially no nutrients, therefore alcohol is of no nutritive benefit to the individual on a hypocaloric diet.[15]

On the other hand, to be realistic in the nutrition therapy and lifestyle modification of the insulin-dependent individual, instruction in how to safely include a moderate amount of alcohol in their diet is necessary. The key fact in educating people with IDDM is how to avoid hypoglycemia when ingesting alcohol. Alcohol and insulin cause a decrease in plasma glucose by decreasing glycogenolysis and gluconeogenesis in a fasted state. The individual on insulin should not consume alcohol in a fasted state. IDDM patients should only ingest alcohol during or after a meal or snack to avoid hypoglycemia.

Alcohol can be included in the diet as fat exchanges because it is metabolized as two carbon fragments, as is fat.[16] The formula used to figure the number of fat exchanges to omit from the diet for an alcoholic beverage is as follows:

$$0.8 \times \text{proof} \times \text{ounces} = \text{kcals} \div 45\text{kcals}$$

(# of kcals/Fat Exchange) = # of Fat Exchanges

Table 3 lists alcoholic beverages and their equivalent fat exchanges.[16]

TABLE 3 — Exchange Equivalents for Alcoholic Beverages[16]

Beverage	Serving Size (oz)	Calories/ Serving	Fat Exchanges*
Beer (regular)	12.0	151	3.5
Beer (low calorie)	12.0	97	2.0
Wine			
red	4.0	83	2.0
dry white	4.0	80	2.0
rosé	4.0	88	2.0
Distilled Spirits	1.5	107	2.0

* 1 fat exchange is equal to 45 calories.

Diabetes and Nutritive Sweeteners

Nutritive sweeteners (sugar alcohols) are defined as calorie-containing sugars. They are used in many dietetic and diabetic food products. These sugars are sorbitol, xylitol, and mannitol. Fructose is not considered a sugar alcohol, but is used as a nutritive sweetener in many of these products. The nutritive sweeteners contain approximately four calories per gram (similar to all carbohydrates). These sweeteners are not of any benefit to NIDDM patients on a hypocaloric diet. An additional consideration is the high cost of these special foods.

An increased interest in nutritive sweeteners has developed recently and centers around an effort to obtain a sweetener for use by individuals with IDDM that will not cause hyperglycemia after ingestion. Researchers believe that the metabolism of the nutritive sweeteners requires less insulin than the metabolism of glucose.[17, 18] There are several enzymatic reactions in the metabolic degradation of these sweeteners, considered to be insulin-independent, as compared with the insulin-dependent reactions of glucose metabolism. The nutritive sweeteners are also absorbed more slowly than the glucose, resulting in a slower rise in glycemia. One disadvantage, however, of the use of these sweeteners is that they can cause osmotic diarrhea if consumed in large quantities.[17] Presently, there is limited research documented in this area, and the long-term use and effectiveness of these substances remains questionable.

Conclusion

There is a renewed interest in using diet as the primary therapeutic tool in the management of patients with NIDDM and as an integral component in the management of patients with IDDM. It should be stressed that any education in the area of diet and nutrition must contain a follow-up component to maximize its effectiveness. To this end, the use of a dietitian/nutritionist can provide an important link to effectively counsel the patient in diabetes management.

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Diabetes Mellitus — A Community Perspective

WOODROW A. GARRETT, JR., M.P.A., and TERRY D. GOLDEN, M.D., *Atlanta**

Introduction

THE CLINICAL ASPECTS of diabetes mellitus as viewed from the perspective of the practicing physician have been addressed in other articles in this issue. The purpose of this paper is to address the public health or community perspective of diabetes mellitus.

Individually, the diabetic patient often requires an inordinate amount of time from the physician; collectively, diabetic patients often require an equally excessive amount of time and services from the medical care delivery system. A true measure of the impact of diabetes would describe the prevalence of ill health among the diabetic population which includes not only mortality and morbidity in hospitals but also illnesses treated outside the hospital and untreated episodes contributing to the excessive morbidity associated with the disease. Knowledge of this information could help identify areas of unmet needs and could serve as the basis for planning community-based preventive measures, such as education programs.

Prevalence and Incidence

Although prevalence surveys for diabetes in the Georgia population have not previously been conducted, race-specific rates obtained from the 1976 Health Interview Survey of the National Center for Health Statistics can be applied to the Georgia population to develop estimates of the number of diabetics in Georgia. These estimates are shown below:

Estimated Number of Diabetic Patients in Georgia

Race	Total Population	Rate/10,000	Estimated Number of Diabetics
White	3,948,007	249	98,305
Non-White	1,516,258	301	45,639
Total	5,464,265		143,944

Additional data from NCHS suggest that for every one diagnosed case of diabetes there may be one undiagnosed case as well. If this were so, the number of diabetics in Georgia would probably be closer to 280,000.

Nationally, the incidence of diabetes has been estimated at .26% per year, which would indicate approximately 14,209 new diabetics in Georgia annually.

Morbidity

Although the actual number of diabetes-related hospitalizations occurring each year in Georgia is not available, the Diabetes Control Program of the Department of Human Resources has access to information which would indicate the relative magnitude of the problem. Data are available on approximately 20% of the total hospitalizations occurring each year in Georgia hospitals. The rate of discharge with diabetes as the primary diagnosis in 1979 was 22.5 per 10,000 population, and the rate of discharge with diabetes as the secondary diagnosis was 58.8 per 10,000 population. Figure 1 shows that the rate of discharge with diabetes mellitus as the primary and secondary diagnosis in Georgia appears to be increasing over the period 1976 to 1979. The U.S. rate for diabetes as the primary discharge diagnosis increased from 26.2 per 10,000 population

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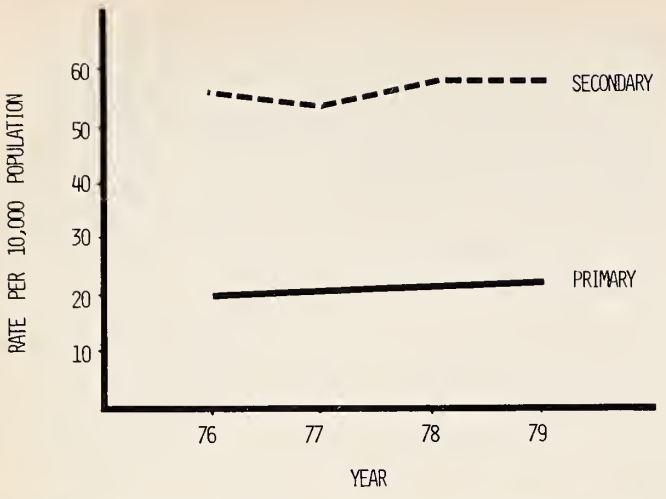


Figure 1 — Rate of Discharge With Diabetes Mellitus as the Primary and Secondary Discharge Diagnosis, Georgia, 1976-1979.

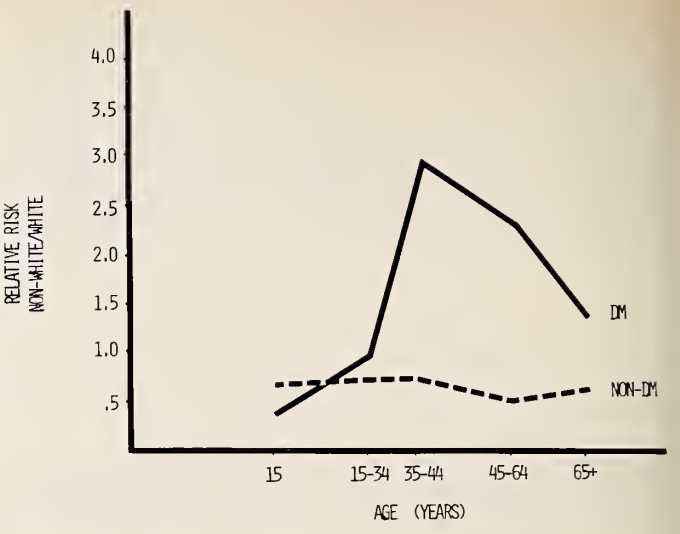


Figure 2 — Relative Risk of Hospitalization, Georgia, 1978-1979 Average.

in 1976 to 27.3 in 1978, and the secondary rates increased from 66.1 in 1976 to 69.0 in 1978. The lower Georgia rates may be attributed to the fact that the major metropolitan-area hospitals were underrepresented in the 20% discharge data set.

Estimated Number of Diabetes-related Hospitalizations in Georgia, 1976-1979

	1976	1977	1978	1979
Diabetes Mellitus as Primary Discharge Diagnosis	9,648	10,610	11,050	11,867
Diabetes Mellitus as Secondary Discharge Diagnosis	26,998	27,165	29,078	30,264

The rate of hospitalization of diabetics increases with age. In 1979, the rate of discharge with diabetes as the primary diagnosis increased from 2/10,000 for ages under 15 to 75/10,000 for those 65 and older. The prevalence of diabetes is also known to be higher among non-whites than whites. As Figure 2 shows, the risk of a non-white diabetic being hospitalized with a primary discharge diagnosis of diabetes is higher compared to a white diabetic in the same age group. Part of this increased rate is due to the increased prevalence of diabetes in the non-white population. For non-white diabetics ages 35-64, for example, the risk of hospitalization is approximately 3 times higher than for white diabetics of the same age group. If the risk of hospitalization for non-diabetic discharges between non-whites and whites is examined (dotted line in Figure 2), the higher risk disappears. This indicates that the excess risk of hospitalization among non-whites in that age group is specific to diabetes and not to other diseases. Reasons for this difference, however, are not known.

There are other indications of the community impact of diabetes-related morbidity. In Fiscal Year 1981, for example, 88 (15%) of the 575 end-stage renal disease patients participating in the Georgia End-Stage Kidney Disease Program had diabetes listed as the primary cause of kidney disease. Vascular disease and peripheral neuropathy resulting in amputations are also known to be major problems among the diabetic population. While the numbers obtained from the hospital discharge survey pertaining to amputations are relatively small, an estimated 547 diabetes-related lower extremity amputations occurred in Georgia in 1979.

The economic costs of diabetes morbidity to the state and to the entire nation are tremendous — exceeded only by cardiovascular disease and cancer in Georgia. Using a conservative estimate of a 5-day stay per patient at $200 per day, the cost of hospitalizations related to diabetes per year in Georgia would be at least as listed at the top of the following page.

Diabetes Mortality

Diabetes as the underlying cause of death has consistently ranked among the top 12 in Georgia in the past decade. During the period 1976 through 1979, the number of deaths due to diabetes, as well as rank and rate per 100,000 population, was as follows:

Deaths Due to Diabetes, Georgia, 1976-1979

	1976	1977	1978	1979
Number of DM Deaths	642	728	659	713
Rank	12	9	11	10
Rate/100,000	12.9	14.5	13.0	13.8

These figures may appear to be lower than the national rate which was 15.0 per 100,000 population for 1979. However, many studies indicate that diabetes is not reported on the death certificate approximately 40% of the time in deaths where diabetes is a

Cost of Hospitalizations Associated with Diabetes Mellitus (DM, 1976-1979)				
	1976	1977	1978	1979
DM as Primary Discharge Diagnosis	$ 9,648,000	$10,610,000	$11,050,000	$11,867,000
DM as Secondary Discharge Diagnosis	26,998,000	27,165,000	29,078,000	30,264,000
Total	$36,646,000	$37,775,000	$40,128,000	$42,131,000

major factor in the terminal illness. Other estimates have suggested that diabetes, with its complications, is the third leading cause of death due to illness and that it decreases life expectancy significantly.

Community-Based Diabetes Control Activities

From the preceding discussion, it is apparent that diabetes is a significant public health problem and reaches beyond the office of the practicing physician. Various strategies and approaches have been used by communities and institutions in response to the problems associated with diabetes. The Diabetes Detection and Control Center of Grady Memorial Hospital, for example, has been a leading proponent of patient and professional education for a number of years. The Grady Diabetes Unit has reported a marked reduction in hospital morbidity among its active patients, a significant reduction in diabetes-related amputations, and a substantial savings to the hospital over the past decade.

A smaller but similar community effort for diabetes control was undertaken in Valdosta. Dr. Charles O. Barker, with the cooperation of the South Georgia Medical Center, the Department of Human Resources, and the local chapter of the ADA Georgia Affiliate, started a patient education program in 1978, consisting of a 3½-hour session once a week for 4 weeks. Patients were given knowledge tests at the beginning and end of the 4-week session and had weight and blood sugars recorded weekly. Dr. Barker's efforts represent a community-based coordinated effort to address the needs of the diabetic population. A preliminary analysis of the first 124 diabetics who attended the course is shown below.

Pre vs Post Measures Associated With 124 Diabetics Involved in a Patient Education Program, Valdosta, GA, 1978					
	Number of Patients	Mean Pre	Mean Post	Difference	Significant
Knowledge Test	105	58.8%	81.5%	+23%	Yes
Nutrition Test	38	62.0%	80.1%	+18%	Yes
Fasting Blood Sugar	123	180 mg%	167 mg%	−13 mg%	Yes
Weight	124	173 lbs.	172 lbs.	−1 lb.	No

The Southeast Health Unit, Department of Human Resources, also started a similar program at the Ware County Health Department. The Ware County program offers educational services to diabetics referred by private physicians and by the health department's adult health program.

The Diabetes Control Program, Department of Human Resources, in a cooperative agreement with the Centers for Disease Control, is coordinating a statewide effort to identify the effective modes of treatment for diabetics at the community level. An 18-member Advisory Committee was established to provide general guidance and direction to the program and to enhance the coordination and communication among resources delivering medical and educational services to the diabetic population.

Acknowledgement

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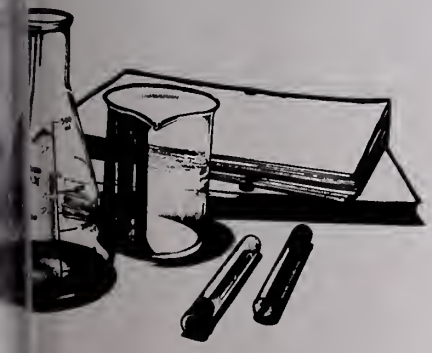
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WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

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Shreveport, Louisiana 71106

A paper of medical historical interest, the landmark case of Leonard Thompson, the first person with diabetes to receive an injection of exogenous insulin on Jan. 11, 1922, is discussed.

A Case of Diabetes Mellitus

GERARD N. BURROW, M.D., BARBARA E. HAZLETT, M.D., and M. JAMES PHILLIPS, M.D., *Toronto, Canada**

A 27-YEAR-OLD diabetic man was admitted to the Toronto General Hospital in severe ketoacidosis after five days of nausea and vomiting.

The patient had had diabetes mellitus for 15 years and had been admitted to the Toronto General Hospital on five previous occasions for control of his disease — once in ketoacidosis and once with severe hypoglycemia.

Six days before the most recent admission, he had joint pains, followed by anorexia, nausea, and vomiting. He was unable to retain food or liquids and had decreased his insulin dose from 80 to 40 units in four divided doses daily. He became increasingly drowsy and was brought to the hospital for admission.

On examination, he was drowsy and uncooperative, with a strong odor of acetone on his breath. His respirations were not of the air-hunger type. His rectal temperature was 37.2°C, pulse 120, and blood pressure 100/60 mm Hg. His skin and tongue were dry, and the pharynx was injected.

Laboratory data included a white-cell count of 13,400 urinary sugar 4+, urinary ketones 2+, blood sugar 286 mg per deciliter (15.9 mmol per liter), and serum ketones 3+.

The patient was treated with 1.5 liters of 10 per cent dextrose solution and 100 units of insulin intravenously. He became able to take orange juice by mouth and was given another 50 units of insulin. Later on the day of admission, his temperature rose to 38.6°C.

The next morning, fine rales were heard over the left lung base. The blood sugar was 350 mg per deciliter (19 mmol per liter), and he was given 50 units of insulin subcutaneously, and then 40 units every four hours. During that day, his temperature rose to 39.6°C.

On the morning of the third hospital day, he was found to be comatose, with a blood sugar of 49 mg per deciliter (2.7 mmol per liter). Rales were present in both lung bases, and he was cyanotic. He was given 100 ml of 50 per cent glucose without obvious change. The presumptive diagnosis of bronchopneumonia was made, and he was placed in an oxygen tent. Therapy was to no avail, and he died at 2:15 p.m. on the third hospital day.

Pathological Findings

Acute bilateral bronchopneumonia with early consolidation of the left lower lobe was considered to be the main cause of death. A blood culture taken post mortem grew *Staphylococcus aureus*.

Another major finding was generalized atherosclerosis with marked involvement of the coronary arteries and aorta. The organs in general were in the low-normal weight range, but the liver was enlarged, weighing 3100 g. Microscopically, the liver cells were greatly swollen and filled with glycogen. The kidneys were grossly normal, but on microscopy, the proximal tubular cells showed glycogenosis — the Armanni-Ebstein lesion that occurs when hyperglycemia is rapidly corrected.[1] There was acute gastritis and esophagitis. The brain showed mild edema with patches of gliosis in the region of the third ventricle.

The pancreas weighed 40 g. On microscopic examination, there was mild fibrosis and the islets were small and difficult to find. There was no lymphocytic infiltration. The islet cells showed hydropic vacuolation of their cytoplasm. Special stains re-

* Drs. Burrow, Hazlett, and Phillips are from the departments of Medicine and Pathology, University of Toronto, Toronto, Canada. This paper was presented in part at a symposium on the 150th Anniversary of the Toronto General Hospital.

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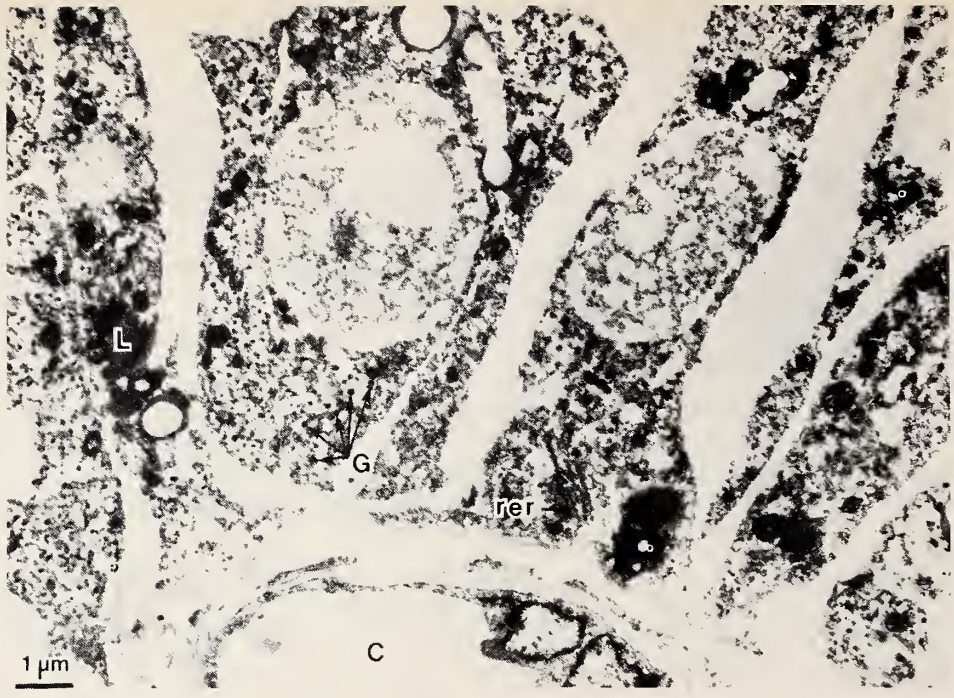


Figure 1 — Electron Micrograph of Pancreas, Showing Portions of Several Islet Cells around a Capillary (C). Note the small electron-dense granules (G) wtihin these cells, the accumulation of lipid material (L), and the rough endoplasmic reticulum (rer) (uranyl acetate and lead citrate stain, ×10,800).

vealed a marked reduction of endocrine cells. Electron microscopy was carried out later. The islets contained numerous small, round, electron-dense endocrine granules in cells situated around a small capillary (Figure 1).

The pathological findings were characteristic of diabetes mellitus.

Discussion

This case of diabetes mellitus is of particular interest because the patient was Leonard Thompson, the first patient in the world to receive insulin, which was first administered on January 11, 1922. The final hospitalization described above occurred in 1935, 13 years after this initial injection of insulin. The suggestion has been made that Thompson lived a normal life after insulin therapy was begun and died from injuries sustained in a motorcycle accident. However, as described above, he died of bronchopneumonia with the complications of diabetes mellitus.

In preparation for a symposium on diabetes mellitus for the 150th anniversary of the Toronto General Hospital, Leonard Thompson's original chart was located in the medical records department, although the information on the first admission in 1921 was missing. In a search of the Pathology Museum his pancreas was found preserved in formalin. Subsequently, the original record was found in the basement of the Hospital for Sick Children.

Leonard Thompson was first admitted to the Toronto General Hospital on December 2, 1921, with nocturia of 2½ years' duration. At this time, he was 13 years old and weighed 29 kg. He was placed on a severely restricted diet comprising only vegetables, to which meat and then fruit were subsequently added, to a total of 450 kcal; his condition improved slightly. His blood sugar ranged from 350 to 560 mg per deciliter (19 to 31 mmol per liter), with variable amounts of ketonuria.

For the previous six months, Frederick G. Banting, an orthopedic surgeon from London, Ontario, and Charles H. Best, a young graduate student, had been striving to purify "isletin" with the support of J. J. R. Macleod, professor of physiology. They were later joined by a biochemist, J. D. Collip. As in so many other major biomedical discoveries, a bitter controversy ensued about the contributions of each of these men.[2]

This case represents the first conversion of what is today insulin-dependent diabetes mellitus from a fatal disease into a chronic illness with degenerative complications.

However, by January of 1922, Banting and Best had prepared a pancreatic extract that lowered the blood sugar in dogs, and they were ready to try it on a patient. Neither Banting nor Best had hospital privileges, and on January 11, Dr. E. D. Jeffrey, an intern, administered 7.5 ml of the extract called "Macleod's serum" into each of the patient's buttocks, under the direction of Dr. Walter R. Campbell. The blood sugar fell from 470 to 320 mg per deciliter (26 to 18 mmol per liter) over the next six hours. This historic event was noted perfunctorily in

the record and charted. No further extract was available, and the patient was kept on a diet. On January 18, an area of induration 7.5 cm in diameter was described in the left buttock. Banting et al. wrote a report on this case and noted that the extract was less concentrated than that used subsequently.[3]

Meanwhile, Collip, the biochemist, had further purified the pancreatic extract, and on January 23, 1922, 5 ml of "Dr. Collip's serum" was injected into the boy's abdomen; 10 ml was injected twice more during the first 24 hours. The blood sugar fell from 520 mg per deciliter (29 mmol per liter) on the morning of January 23 to 120 mg per deciliter (6.7 mmol per liter) at 5 a.m. the next morning. At 11:30 p.m. on the night of January 24, after two more 10-ml injections into the pectoral area, the blood sugar was 100 mg per deciliter (5.5 mmol per liter). Dr. Collip's extract was clearly more potent than the Macleod extract. Leonard Thompson continued to receive the new extract for 10 days, with marked improvement.

He was discharged from the hospital on May 15, 1922, weighing 30.6 kg. On his next admission on October 22, 1922, he weighed 25 kg and was in diabetic ketoacidosis. He was treated with "Iletin" from that time on and he was discharged on April 23, 1923, weighing 36 kg.

With insulin treatment, Leonard Thompson lived a relatively normal life, working intermittently and on occasion even playing baseball. He was on a diet containing 50 g of protein, 160 g of fat, and 100 g of carbohydrate, and he remained under the care of Dr. Campbell. His insulin dose was increased from 15 units in the morning and 8 units in the evening to 30 units before breakfast, 25 units before lunch, 20 units before supper, and 20 units at bedtime. He died of bronchopneumonia, as described above, on April 20, 1935.

There seems to have been no real comprehension at that time that the first injection of insulin to a diabetic patient was a major milestone in medical history. Shortly afterward, reports abounded that insulin represented the cure for diabetes mellitus. Despite insulin treatment, Leonard Thompson died with a number of complications of the disease, and the debate still continues about whether insulin, even in optimal amounts, can "cure" diabetes mellitus.

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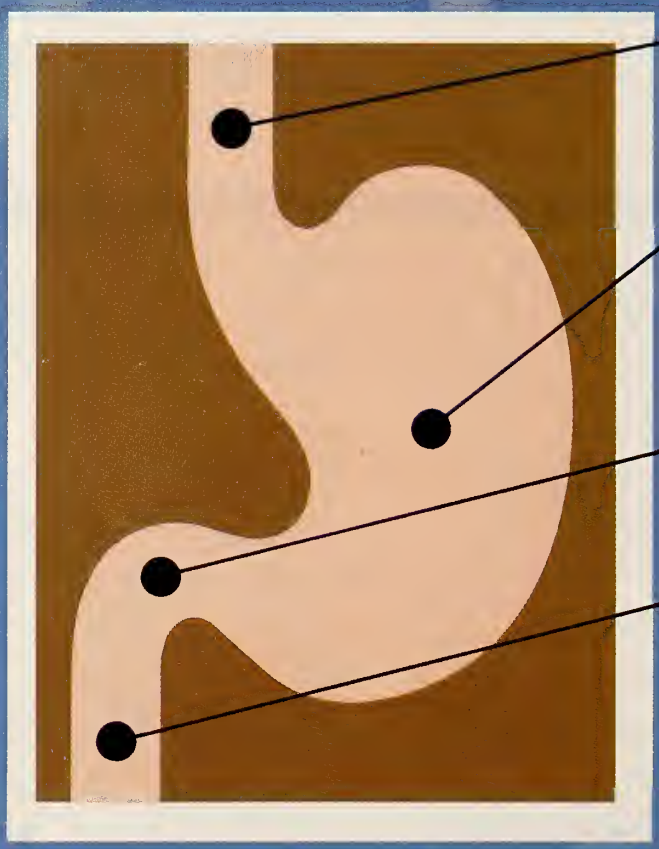
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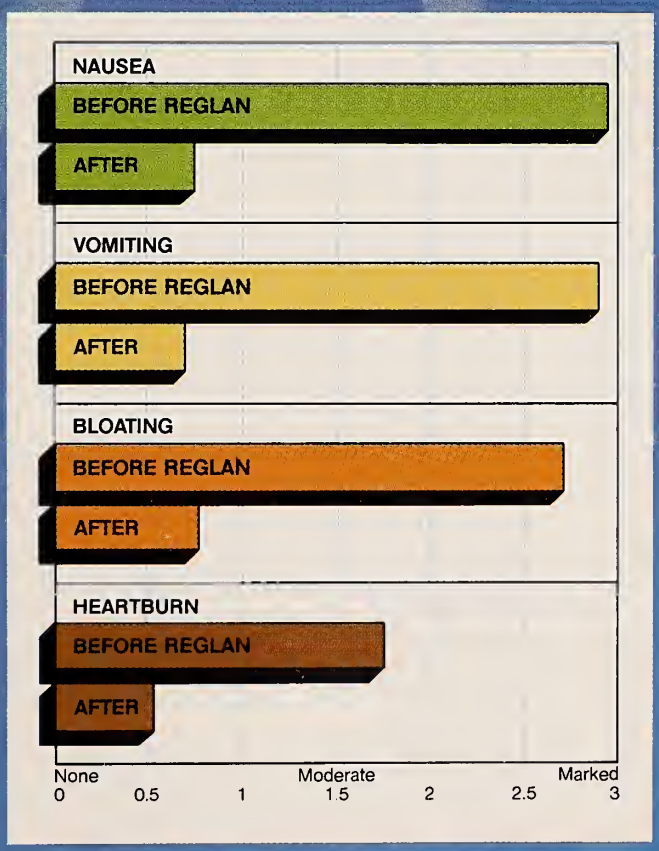
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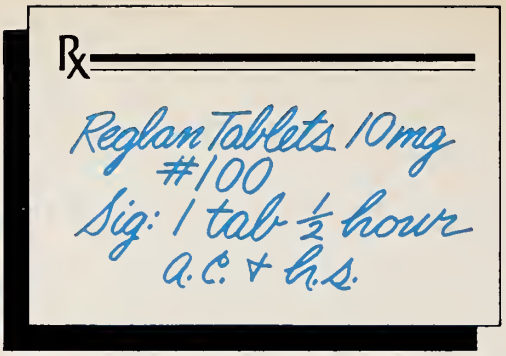
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REGLAN® TABLETS



(Metoclopramide Hydrochloride) 10 mg

REGLAN®
(Metoclopramide Hydrochloride)
Tablets

Description: Reglan Tablets are white, round, compressed tablets monogrammed AHR and REGLAN.

Each tablet contains:
Metoclopramide base, 10 mg
(as the monohydrochloride monohydrate)

Metoclopramide hydrochloride is a white crystalline, odorless substance, freely soluble in water. Chemically, it is 4-amino-5-chloro-N-[2-(diethylamino) ethyl]-2-methoxy benzamide monohydrochloride monohydrate. Molecular weight: 354.3.

Clinical Pharmacology: Metoclopramide stimulates motility of the upper gastrointestinal tract without stimulating gastric, biliary, or pancreatic secretions. Its mode of action is unclear. It seems to sensitize tissues to the actions of acetylcholine. The effect of metoclopramide on motility is not dependent on intact vagal innervation, but it can be abolished by anticholinergic drugs.

Metoclopramide increases the tone and amplitude of gastric (especially antral) contractions, relaxes the pyloric sphincter and the duodenal bulb, and increases peristalsis of the duodenum and jejunum resulting in accelerated gastric emptying and intestinal transit. It increases the resting tone of the lower esophageal sphincter. It has little, if any, effect on the motility of the colon or the gallbladder.

Like the phenothiazines and related drugs, which are also dopamine antagonists, metoclopramide produces sedation and may produce extrapyramidal reactions, although these are comparatively rare. (See Warnings.) Metoclopramide inhibits the central and peripheral effects of apomorphine, induces release of prolactin and causes a transient increase in circulating aldosterone levels.

The onset of pharmacological action of metoclopramide is 30 to 60 minutes following an oral dose; pharmacological effects persist for 1 to 2 hours.

Approximately 85% of the radioactivity of an orally administered radioactive dose appears in the urine within 72 hours. Of the 85% eliminated in the urine, about half was present as free or conjugated metoclopramide.

Indications and Usage: *Diabetic gastroparesis.* Reglan (metoclopramide hydrochloride) Tablets are indicated for the relief of symptoms associated with acute and recurrent diabetic gastroparesis. The usual manifestations of delayed gastric emptying (i.e., nausea, vomiting, persistent fullness after meals and anorexia) appear to respond to Reglan within different time intervals. Significant relief of nausea occurs early and continues to improve over a three-week period. Relief of vomiting and anorexia may precede the relief of abdominal fullness by one week or more.

Contraindications: Metoclopramide should not be used whenever stimulation of gastrointestinal motility might be dangerous, e.g., in the presence of gastrointestinal hemorrhage, mechanical obstruction, or perforation.

Metoclopramide is contraindicated in patients with pheochromocytoma because the drug may cause a hypertensive crisis, probably due to release of catecholamines from the tumor. Such hypertensive crises may be controlled by phentolamine.

Metoclopramide is contraindicated in patients with known sensitivity or intolerance to the drug.

Metoclopramide should not be used in epileptics or patients receiving other drugs which are likely to cause extrapyramidal reactions, since the frequency and severity of seizures or extrapyramidal reactions may be increased.

Warnings: Extrapyramidal symptoms occur in approximately 1 in 500 patients treated with metoclopramide. These occur more frequently in children and young adults and may occur after a single dose. These most often consist of feelings of restlessness; occasionally they may include involuntary movements of limbs and facial grimacing; rarely, torticollis, oculogyric crisis, rhythmic protrusion of tongue, bulbar type of speech or trismus. One dystonic reaction resembling tetanus has been reported.

Precautions: *General.* Patients should be cautioned about engaging in activities requiring mental alertness for a few hours after the drug has been administered.

Drug Interaction. The effects of metoclopramide on gastrointestinal motility are antagonized by anticholinergic drugs and narcotic analgesics. Additive sedative effects can occur when metoclopramide is given with alcohol, sedatives, hypnotics, narcotics, or tranquilizers.

Absorption of drugs from the stomach may be diminished (e.g., digoxin) by metoclopramide, whereas absorption of drugs from the small bowel may be accelerated (e.g., acetaminophen, tetracycline, levodopa, ethanol).

Carcinogenesis, Mutagenesis. Metoclopramide elevates prolactin levels and the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin-dependent *in vitro*, a factor of potential importance if the prescription of metoclopramide is contemplated in a patient with previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported with prolactin-elevating drugs, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of prolactin-stimulating neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is too limited to be conclusive at this time.

Pregnancy Category B. Reproduction studies performed in rats, mice, and rabbits by the i.v., i.m., s.c. and oral routes at maximum levels ranging from 12 to 250 times the human dose have demonstrated no impairment of fertility or significant harm to the fetus due to metoclopramide. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when metoclopramide is administered to a nursing mother.

Adverse Reactions: The most frequent adverse reactions to metoclopramide are restlessness, drowsiness, fatigue, and lassitude, which occur in approximately ten percent of patients. Less frequently, insomnia, headache, dizziness, nausea, or bowel disturbances may occur.

Overdosage: Symptoms of overdosage may include drowsiness, disorientation and extrapyramidal reactions. Anticholinergic or antiparkinson drugs or antihistamines with anticholinergic properties may be helpful in controlling the extrapyramidal reactions. Symptoms are self-limiting and usually disappear within 24 hours.

Dosage and Administration: *For the relief of symptoms associated with diabetic gastroparesis:* Administer one tablet of metoclopramide 30 minutes before each meal and at bedtime for two to eight weeks, depending upon response and the likelihood of continued well-being upon drug discontinuation. Since diabetic gastroparesis is frequently recurrent, Reglan therapy should be reinstituted at the earliest manifestation.

How Supplied: Each white, round, scored, compressed Reglan® Tablet contains 10 mg metoclopramide base (as the monohydrochloride monohydrate). Available in bottles of 100 (NDC 0031-6701-63), and 500 tablets (NDC 0031-6701-70) and Dis-Co® Unit Dose Packs of 100 tablets (NDC 0031-6701-64).

Rev. October 1981

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A review of the epidemiology of this disease in Georgia and a discussion of the principles of diagnosis, treatment, and prevention.

Rocky Mountain Spotted Fever in Georgia — 1975-1980

J. DAVID SMITH, B.S., RICHARD A. GOODMAN, M.D., RALPH L. RAMSEY, A.B., *and* R. KEITH SIKES, D.V.M., M.P.H., *Atlanta**

Summary

The number of cases of Rocky Mountain spotted fever (RMSF) identified in Georgia has steadily increased since 1975. In the period 1975-1980, epidemiologic data were obtained on 346 identified cases; laboratory confirmation was obtained on 185 (53.5%) of the cases. Fifteen of the patients died (case-fatality ratio = 4.3%). This paper reviews the epidemiology of RMSF in Georgia and discusses principles of diagnosis, treatment, and prevention of the disease.

Introduction

Rocky Mountain spotted fever (RMSF) is an acute, febrile illness caused by infection with the organism, *Rickettsia rickettsii,* which is usually transmitted to humans by the bite of an infected tick. Although this disease was initially associated with the Rocky Mountain region of the United States,[1] in recent years the incidence has been greatest in the Southeastern states.[2, 3]

In Georgia, RMSF has been a notifiable disease since 1933. A notable increase occurred in 1975 in contrast to the lower incidence observed for the preceding 15 years. This article presents the epidemiology of RMSF for the period 1975-1980 and reviews principles of diagnosis, treatment, and prevention of this disease.

* Mr. Smith, Dr. Goodman, and Dr. Sikes are with the Office of Epidemiology, Family Health Services Section, GA Dept. of Human Resources; Dr. Goodman is also with the Field Services Division, Epidemiology Program Office, Centers for Disease Control, Atlanta, and Mr. Ramsey is with the Electron Microscopy Laboratory, GA DHR. Send reprint requests to Mr. Smith, Office of Epidemiology, Room 13-H, 47 Trinity Ave., SW, Atlanta, GA 30334-1202.

Tick Ecology

The vector of RMSF in Georgia is the American dog tick, *Dermacentor variabilis.* A study of the distribution and prevalence of this tick was undertaken in 1952 by the State Office of Epidemiology. Ticks were collected both by dragging in selected areas of the state and by removal from host animals. In addition, since 1975, physicians and health departments have submitted to the Office of Epidemiology for identification ticks which have been removed from patients.[4]

D. variabilis has been identified in all areas of Georgia, but it is more prevalent in the hilly and mountainous areas north of the Piedmont Fall Line — a hypothetical line extending from Augusta (Richmond County) to Columbus (Muscogee County) which divides the state into two physiographic regions (Figure 1). *D. variabilis* has also been consistently identified in the upper and lower coastal plains regions south of the Fall Line; however, a different species of tick, the *Amblyomma americanum,* is more prevalent in these regions.

Methods of Surveillance

Each week the Office of Epidemiology receives reports of RMSF cases from physicians and hospitals as part of the statewide notifiable disease reporting system. In addition, laboratory tests confirming RMSF also are reported by private clinical and state laboratories. A standard case history form is used to obtain information for each suspected case, including demographic data, date of onset of illness, outcome of illness, and history of tick exposure.

Patients were classified as either clinically diagnosed (i.e., presumptive) or laboratory-confirmed

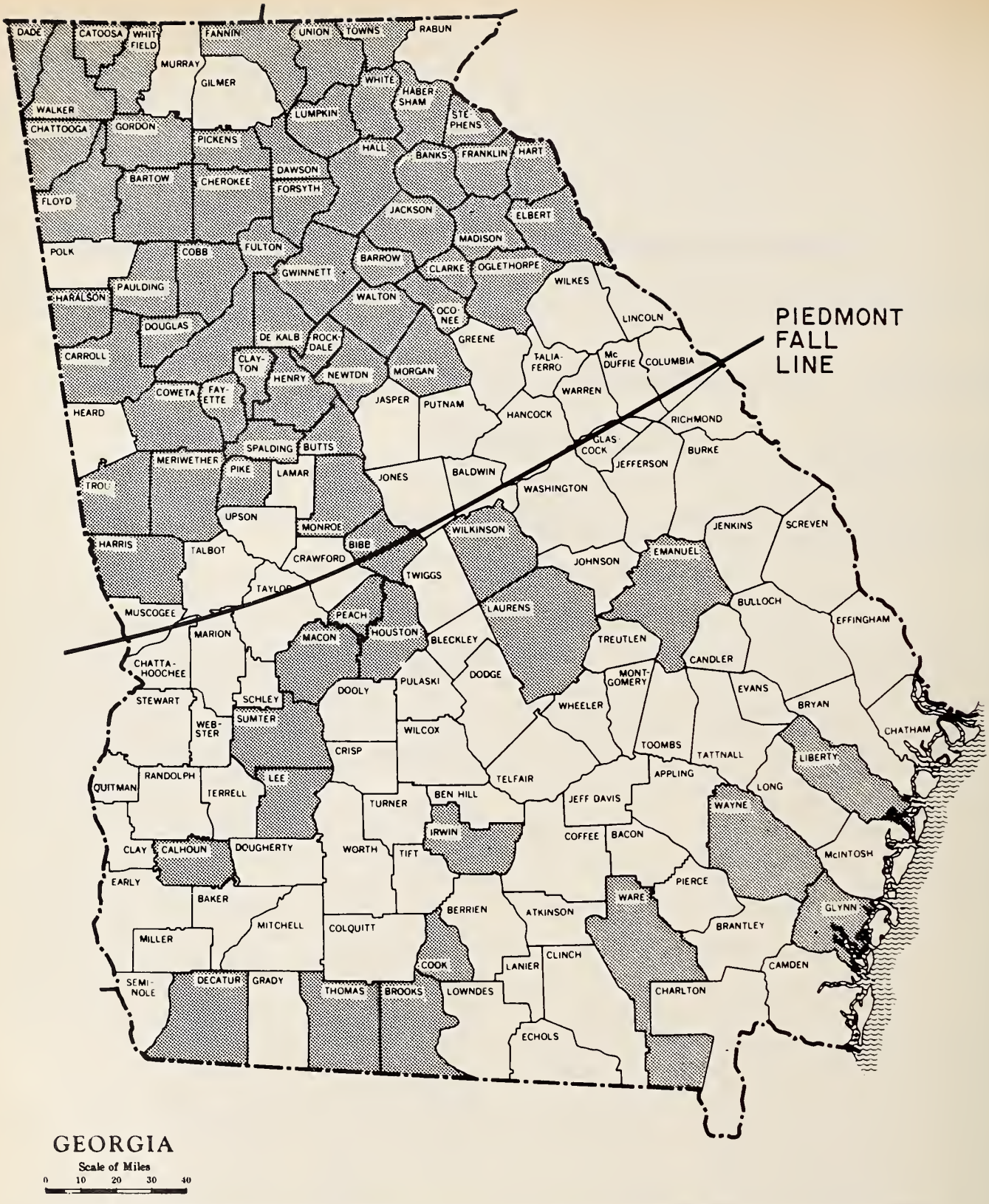


Figure 1 — Counties (shaded) in which *Dermacentor variabilis* was identified for the period 1952-1980.

cases. A clinical case required the presence of: fever (≥101°F), headache, and either a history of tick exposure in the 14 days preceding onset of illness or the development of a maculopapular rash within 1 week following onset.

A laboratory-confirmed case required one or more of the following: 1) a 4-fold (diagnostic) titer rise of either complement fixation (CF) antibody against the spotted fever group antigen or antibody to the proteus OX-19 antigen; 2) a single antibody titer to proteus OX-19 ≥1:160 or a CF titer ≥1:16 in a clinically compatible case; or 3) isolation of the rickettsial organism by culture.[5]

Analysis

A total of 346 cases of RMSF were identified in the period 1975-1980, including 161 clinically diagnosed cases and 185 laboratory-confirmed cases,



Figure 2 — The annual incidence of RMSF per 100,000 Georgia residents for the period 1940-1980.

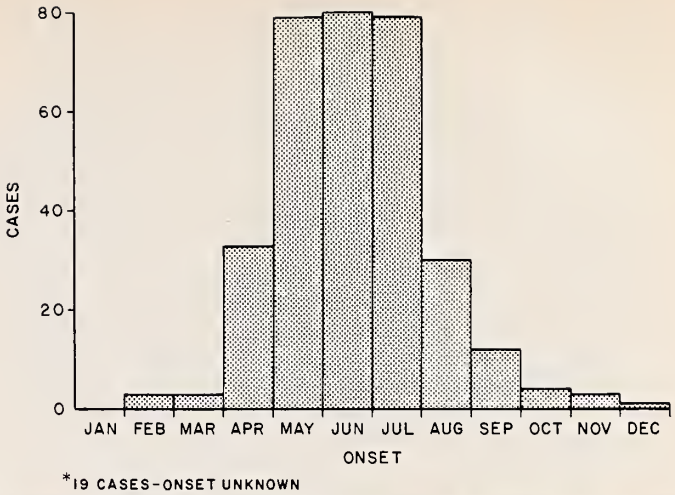


Figure 3 — Cases of RMSF, by month of onset, 1975-1980.

TABLE 1 — Rocky Mountain Spotted Fever, by Age Groups, Georgia, 1975-1980

Age (years)	Number	Percent Total
< 1	0	—
1 – 4	29	8.4
5 – 9	85	24.6
10 – 14	70	20.2
15 – 19	27	7.8
20 – 24	22	6.4
25 – 29	14	4.1
30 – 34	17	4.9
35 – 39	14	4.0
≥ 40	52	15.0
Age Unknown	16	4.6
Total	346	100.0

TABLE 2 — Reported Cases and Deaths in Patients with Rocky Mountain Spotted Fever, Georgia, 1975-80*

Race	Cases	Incidence†	Deaths	Case-Fatality Ratio
Whites	284	1.3	8	2.8%
Blacks	34	0.4	7	20.6%
Total	318	1.0	15	4.7%

* Race unknown for 28 cases of RMSF.
† Based on 1977 mid-point population census estimates.
$x_2 = 28.8$, $P < .005$.

for an average annual incidence of 1.1 cases/100,000 residents. Figure 2 shows the annual incidence since 1940 of RMSF per 100,000 Georgia residents. The highest rate, 1.6 cases per 100,000, occurred in 1979. A total of 184 (53.2%) of the cases occurred in children less than 14 years of age (Table 1); 15 of the cases were fatal (case-fatality ratio = 4.3%).

Onset of illness occurred in May, June, or July for 238 (68.8%) of the cases (Figure 3). In contrast, only four cases had onset in the winter months of December-February. Three hundred patients (86.7%) resided north of the Piedmont Fall Line (Figure 4); 77 (22.4%) resided in the 4-county metropolitan Atlanta area (Fulton, DeKalb, Cobb, and Clayton counties). Fulton County accounted for 29 (8.4%) of the cases identified. Two of the deaths which occurred in residents of Fulton County were attributed to direct laboratory exposure to RMSF.[6]

Race and sex data were obtained for 318 (91.9%) of the cases; 284 (90.3%) occurred in whites, and 34 (10.7%) occurred in blacks. A total of 216 (67.9%) cases occurred in males. White males accounted for 194 (61.0%) cases. The average annual incidence for whites was 1.3 cases/100,000, compared with an incidence of 0.4 cases/100,000 in blacks ($x_2 = 38.8$, $P < .005$) (Table 2). Eight fatal cases occurred in whites (case-fatality ratio = 2.8%) and seven in blacks (case-fatality ratio = 20.6%) ($x_2 = 17.2$, $P < .005$).

The ratio of laboratory-confirmed cases to clinically diagnosed cases was determined for urban areas (i.e., counties with >20,000 persons) and rural areas (i.e., counties with <20,000 persons). The ratio for urban areas was 1.5 compared to 0.9 for rural areas, suggesting that laboratory confirmation is less likely to be obtained for persons who live in rural areas.

Discussion

Since 1944, half of all cases of RMSF in the United States have been reported by the South Atlantic states; Georgia has consistently ranked within the top seven states in the number of cases reported. In 1980, the 321 cases reported by North Carolina represented the highest incidence in the United States (5.46/100,000); Georgia reported 60 cases, an incidence of 1.10/100,000.[3] The Georgia data strengthen the observation that in the eastern seaboard states cases occur in both mountainous and coastal areas.[1]

The apparent increased incidence of RMSF in Georgia in recent years parallels the national experience. Hattwick, et al.[2] suggested several possible explanations for the increase: as total population growth and the process of suburbanization have in-

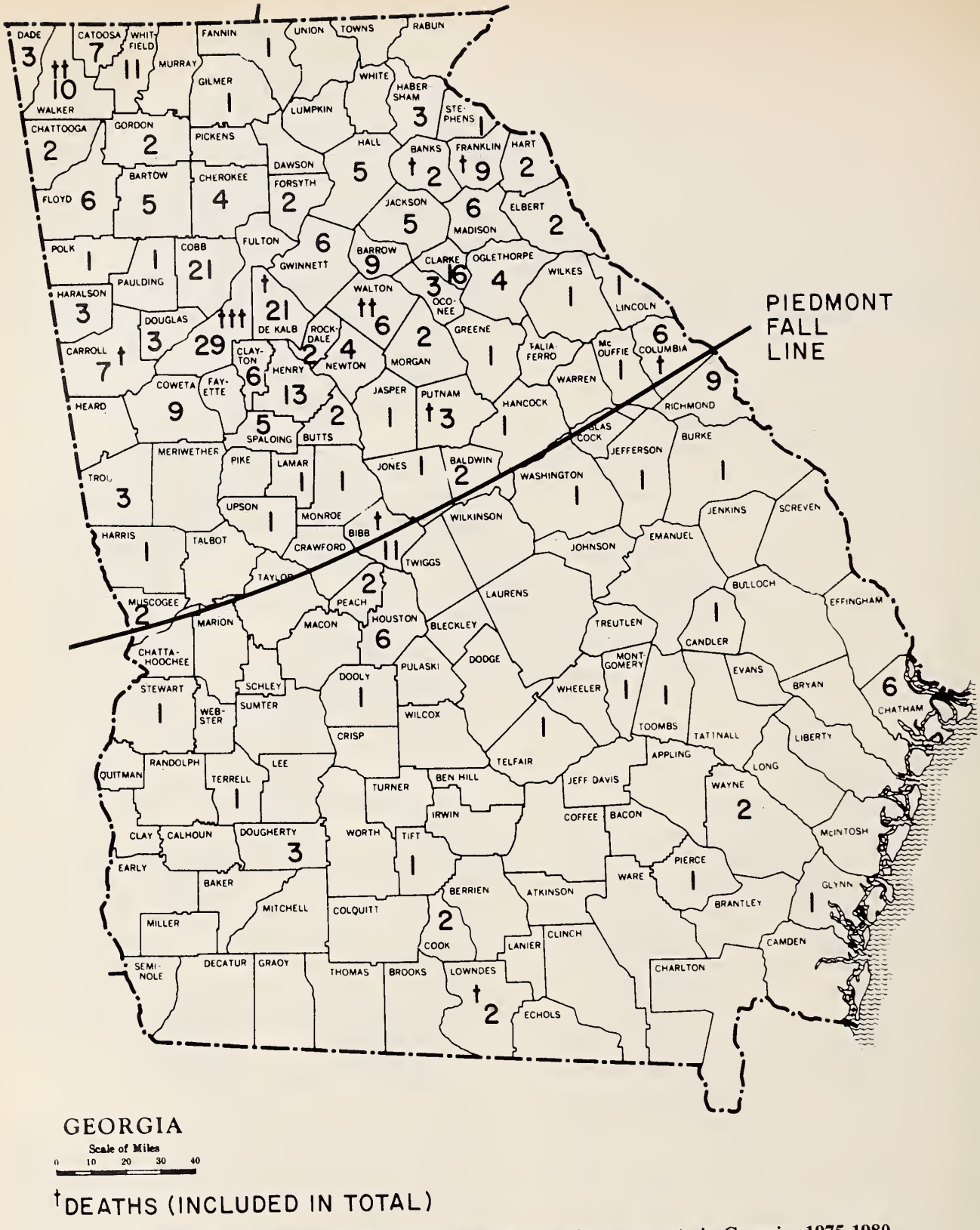


Figure 4 — The number of RMSF cases and deaths per county in Georgia, 1975-1980.

creased, more people have been exposed to infected ticks in forests and recreation areas, and as physicians and the public have become increasingly aware of this disease, its diagnosis and reporting have increased. Although these reasons help to explain the increasing number of cases, the rise may also reflect a true increase in the incidence of this disease.

The tick survey was undertaken to identify the different species prevalent in Georgia and their distribution. *D. variabilis* was identified in all areas of the state but was the predominant tick north of the Piedmont Fall Line. RMSF occurred in 300 (86.7%) residents living in this area of the state; however, approximately 88% of the population resides in this area.

The Georgia data indicate significant racial differences in both the incidence of RMSF and the case-fatality ratios. While the true incidence may be decreased for blacks, this difference might also reflect difficulty in identifying the characteristic rash in

blacks — and thus establishing the clinical diagnosis — and less access to medical care.[2] These same factors may help to explain why the case-fatality ratio is increased in blacks. The high proportion of fatality among black males is also consistent with the national experience.[2]

Diagnosis

RMSF is characterized by the sudden onset of fever, headache, chills, and conjunctival infection. A maculopapular rash usually appears on about the third day of illness. The rash is initially present on the extremities and then spreads to the trunk, palms, and soles.[7] Diagnosis may be aided by a history of recent tick exposure or tick bite. RMSF should be considered in the differential diagnosis of acute febrile exanthematous illnesses including measles, atypical measles, meningococcemia, rubella, murine typhus, toxoplasmosis, enterovirus infections, infectious mononucleosis, typhoid fever, drug reactions, septicemia, rheumatic fever, leptospirosis, Bullis fever, and scarlet fever (particularly when such illnesses occur in the summer months).[2]

Because other febrile exanthematous illnesses are similar to RMSF, clinical diagnosis may be difficult. Thus, specific laboratory testing is important to confirm the clinical diagnosis, although such confirmation should not delay the initiation of therapy. The CF test and the immunofluorescent antibody (IFA) test are readily available to physicians and are specific for RMSF. Paired serum samples are required for these tests: the acute-phase specimen should be obtained within 3 days of the onset of illness and the convalescent-phase specimen at 14-21 days. Both specimens should be submitted at the same time for testing. However, it is important to note that antibodies may not become detectable for 4 weeks after onset.[8] Because several other febrile illnesses may cause elevated proteus OX-19 agglutinins, this test should be used primarily as an adjunct to the CF and IFA tests.

The Georgia data also indicate that a higher percentage of the cases occurring in urban areas are laboratory confirmed. This suggests that diagnostic laboratory tests are not used as frequently by physicians in rural areas and should be used to increase confirmation of clinically suspected cases.

Treatment

Tetracycline and chloramphenicol remain the antibiotics of choice for treating RMSF.[9] Early diagnosis and prompt administration of the proper antibiotics can lower the death rate significantly; thus, treatment must not be delayed while awaiting laboratory confirmation. The fatality rate may approach 20% in the absence of specific therapy.[7]

Prevention

RSMF is a preventable disease and preventive measures relate directly to understanding tick ecology. Humans are accidental hosts for the tick and may encounter the tick in regions of its natural habitat, including wooded areas and underbrush lining animal pathways and roadsides. It is believed that a tick must be attached to its host for at least several hours (possibly >6) before transmission of the rickettsial organisms occur. Thus, persons visiting tick-infested areas should be advised to perform several body searches each day and remove attached ticks immediately. The proper technique for removal of ticks from the body is also very important. Pointed tweezers should be used to grasp the tick as near to the point of skin attachment as is possible; firm, steady traction should then be applied. Such traction allows the tick to be removed without breaking off the mouth parts. After removal of the tick, the bite area should be thoroughly cleansed by washing and/or swabbing the area with isopropyl alcohol. Using insect repellants and limiting skin exposure by wearing long trousers (tucked into socks and boots) and long-sleeved garments may reduce possible tick exposure. Clothing should be liberally treated with insect repellant; frequent re-applications may be necessary for periods of long exposure.

Cases of RMSF should be reported directly to the local health department or to the Office of Epidemiology, Georgia Department of Human Resources. Reporting is important if risk factors and high occurrence areas are to be determined.

Acknowledgements

The authors are indebted to physicians and hospital infection control nurses for their assistance in maintaining RMSF surveillance in Georgia. The authors also thank T. McKinley, T. Munro, and J. McDade for their contributions to this report and Mrs. E. Brock for her excellent preparation of the manuscript.

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In addition to the political problem [of the high cost of medical care], many of the reforms desired by the sociologists fall within the realm of disciplines other than the delivery of medical care (the physician's function).

Physician Control of the Health Care System — Fact or Fancy?

JAMES W. HOLSINGER, JR., M.D., *Richmond, Virginia**

Introduction

In order to determine if physicians control the health care system, a variety of questions may be posed. For example, what is the current status of the health care system? Second, does the physician actually dominate the health care system, and if so, does he control it? Third, if he does control the system, is the physician thwarting attempts at reform, providing such reform is needed? And lastly, is physician control of the health care system detrimental to the provision of health care? In this paper we will look at each of these questions, using the last to summarize the answers provided to the preceding ones.

Who Controls the Health Care System?

Health care in the United States today is provided by a wide variety of health care practitioners with the physician traditionally occupying the leadership role. Historically, the physician developed as the health care provider, and subsequently other health care professions were developed to assist the physician to provide care. Initially, the physician was able to provide little other than a caring function.[1] However, with the advent of antibiotics and other scientific aspects of the biological sciences, he developed the capability to at least influence the outcome of certain diseases (notably infectious diseases). In the first 40 years of this century, the country general practitioner became the archetype of the physician.[1] In this period, the population of the United States changed from a predominantly rural to a predominantly urban society. Scientific advances occurred at a geometric rate and in conjunction with these changes, the growth of specialization within the profession occurred.[2] This combination of an explosion in scientific knowledge in conjunction with the shift in population to the urban setting resulted in a marked change in the delivery of medical care. The physician specialist has changed the approach to medical care with a resulting nostalgia for the general practitioner.[1] However, few physicians today would readily admit to a capability of remaining current in all phases of medicine. To be competent in one specialty alone is a difficult task. Most Americans desire ready access to a generalist for the treatment of minor illnesses, triage, night calls, and hopefully house calls, but readily assert their interest in being treated by the "best," i.e., the specialist, whenever true disaster strikes.

The physician remains today the central decision-maker in the provision of direct care to the patient. He himself often acts as the cure itself. With such a role has come tremendous prestige, respect, tangible rewards, and, when the patient's condition is dire and the treatment effective, adulation. The physician's role is considered one of the most responsible roles in our society. He is the central figure in the health care system and to a large degree the system revolves around him. Some of the most capable and intelligent individuals in our society may be found in this profession, and tremendous drive and ambition appear to be required for an individual to gain entry to it. The desire to become a physician is often found early in life in those who aspire to become one. The education and training is lengthy, requiring the ability to delay many pleasures until later in life.[3]

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Although well paid, the physician is not normally driven by his ability to command a high income.[4] Instead, the driving force for physicians has been a desire to treat patients with interesting clinical problems. As intelligent and capable human beings, physicians are interested in treating patients that have interesting problems which challenge their professional training.[5]

The relationship between the physician and patient is the focal point in the provision of medical care.[6] This relationship is fundamental. One of its key elements is the power relationship between the patient and the physician.[6] This relationship is not found in the encounter of the patient with any other health care professional. In placing himself in the hands of the physician, the patient is acknowledging this relationship. He is accepting the knowledge, integrity, and competence of *his* physician as well as his own implied trust in the physician's ability to assist in the correction of his malady, whether physical, emotional, or both. Although there are a variety of other health care professionals available and interested in his care, the patient accepts this relationship only from the physician.

The relatively simple solution of requiring a significant copayment would break the cycle which results in ever-increasing [health care] costs.

The status of the health care system in the United States is undergoing close scrutiny. As it has evolved to date, this system has provided a high level of western scientific medical care to the American population. As various illnesses are treated, usually within the hospital if serious, a significant reduction in mortality if not morbidity for certain diseases or conditions has occurred. This does not mean that the population lives longer; it only means that it lives better insofar as its symbiosis with disease is concerned. All but 6 million Americans have health insurance coverage through some combination of third party payment systems and thus have access to the health care system.[7] The other 5% may not seek care, may not need care, may not know they need care, or may not know how to obtain care. However, it is difficult to place the blame for the failures of the health care system on the physician, when historically the physician has served as the provider of medical care — not a guarantor of the health status of the American population. The current status of the health care system is mixed, in that there is a high level of *medical* care provided to the vast majority of the population but with the caveat that *health* care has not attained to such a high level. The latter is a relatively new concept, particularly if health is defined by using the World Health Organization definition: ". . . a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[8] The physician has yet to thrust himself upon the American population as the purveyor of "health" according to this definition.

The physician clearly dominates the delivery of *medical* care in the United States. Although there is a plethora of health care professions, to date none have provided the patient with the care that he has traditionally sought from the physician. In fact, each of these health care professions has been developed to assist the physician as the terminology applied to them indicates (i.e., physician extender, allied health professionals, etc.). To a large extent the physician does dominate the health care system. It is to his knowledge, ability, and competence that the patient turns in his period of illness. Although he on occasion fails to meet the total needs of his patient, the physician continues to attempt to provide expert medical care to those who seek it. However, it is one thing to dominate the system (i.e., the physician has a commanding or preeminent position within the system) and quite another to overtly control it (i.e., to have power over it, to rule or regulate it). In fact, with the degree of governmental regulation which has accrued in the recent past, it is impossible to categorically state that the physician is in control of the health care system.

There is a growing concern not only among politicians and sociologists but also among the population at large that there is something wrong with the health care system. Unfortunately, it is politically expedient on the part of a politician to find a scapegoat for the ills which beset society. Such a scapegoat is rarely the true cause of the problem. There are two major reasons for this attitude: first, the rising cost of health care without a concomitant increase in the "health" (WHO) of the population, and second, the inadequate medical care provided to the underinsured or uninsured poor. Hospital costs have increased 185% in the past 10 years as compared to the average increase in costs of 99%.[9] These climbing costs are invariably attributed to the physician.

All but 6 million Americans have health insurance coverage through some combination of third party payment systems and thus have access to the health care system.

However, in the hospital it is rare to find a physician chief executive officer, and it is also rare to find a majority of the members of the board of trustees to be physicians. It is easy to demand that the physician control costs and reduce demand, but at the same

time maintain the quality and quantity of services provided. But those politicians calling for such assistance from the physician have never been in the position of dealing firsthand with the patient. Each person when confronted with an illness invariably desires "the best." When ill, nothing is too good and nothing costs too much, for when an individual does not have his health, it is worth anything to regain it. But once regained, there is nothing worth less.

Certain reforms are needed in the system, but to believe that the physician has either the power to produce the change or capability to effect such change is erroneous. The problems of "health" today are not so much problems of the provision of medical care as they are political in nature. The major problem of increasing costs had a political origin and presumably warrants a political solution. We can find the roots of this problem in the philosophy that government can cure all ills including those of the health care system. The introduction of free medical care for the elderly and poor with the institution of the mediplans has had a marked effect on the rate of rise in the costs of health care. The relatively simple solution of requiring a significant copayment would break the cycle which results in ever-increasing costs. Such a solution is beyond the capability of the physician (or even organized medicine) to implement. It is obvious that this solution is not politically acceptable.

With the degree of governmental regulation which has accrued in the recent past, it is impossible to categorically state that the physician is in control of the health care system.

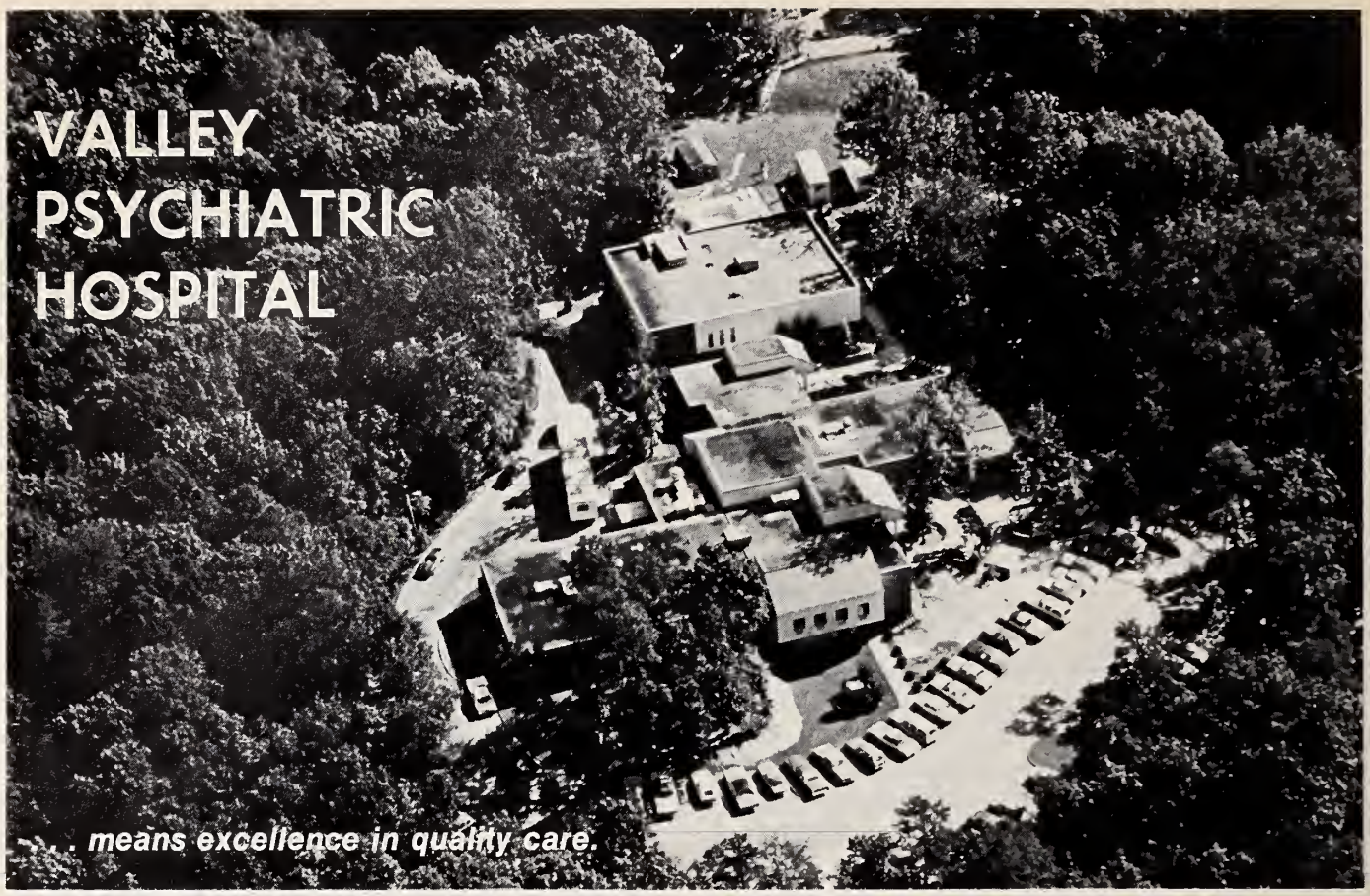
In addition to the political problem, many of the reforms desired by the sociologists fall within the realm of disciplines other than the delivery of medical care (the physician's function). These problems include, among many others, the drunk driver that contributes to 50% of highway fatalities, the inadequacies of our educational system which turns out not only illiterates but also graduates without even a rudimentary knowledge of the care of their bodies, an insurance industry which appears to be incapable of working with hospitals to develop a program which would result in lower costs, and a hospital industry which has used the "demands" of physicians as an excuse for refusing to recognize the Law of Diminishing Marginal Returns. The physician indeed must be a paragon of brilliance, accomplishment, and virtue in order to provide the positive leadership needed to reform a system which he no longer controls.

Summary

The physician in the past not only dominated the health care system but controlled it as well. However, in 1982, it is difficult to demonstrate that he is still in control of the health care system. In fact, he is as much a victim of the system as his patient. Perhaps a future generation will look back to the 1960s and recognize the opposition of organized medicine to the passage of the Mediplan legislation as a most statesman-like action. Certainly physician dominance of the provision of *medical* care is not detrimental to the care of the patient. Perhaps on a broader scale, the control of the health care system by the physician would once again prove beneficial to the provision of "health" to the American population.

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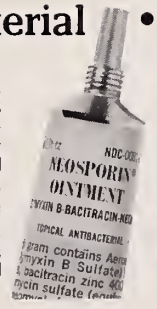
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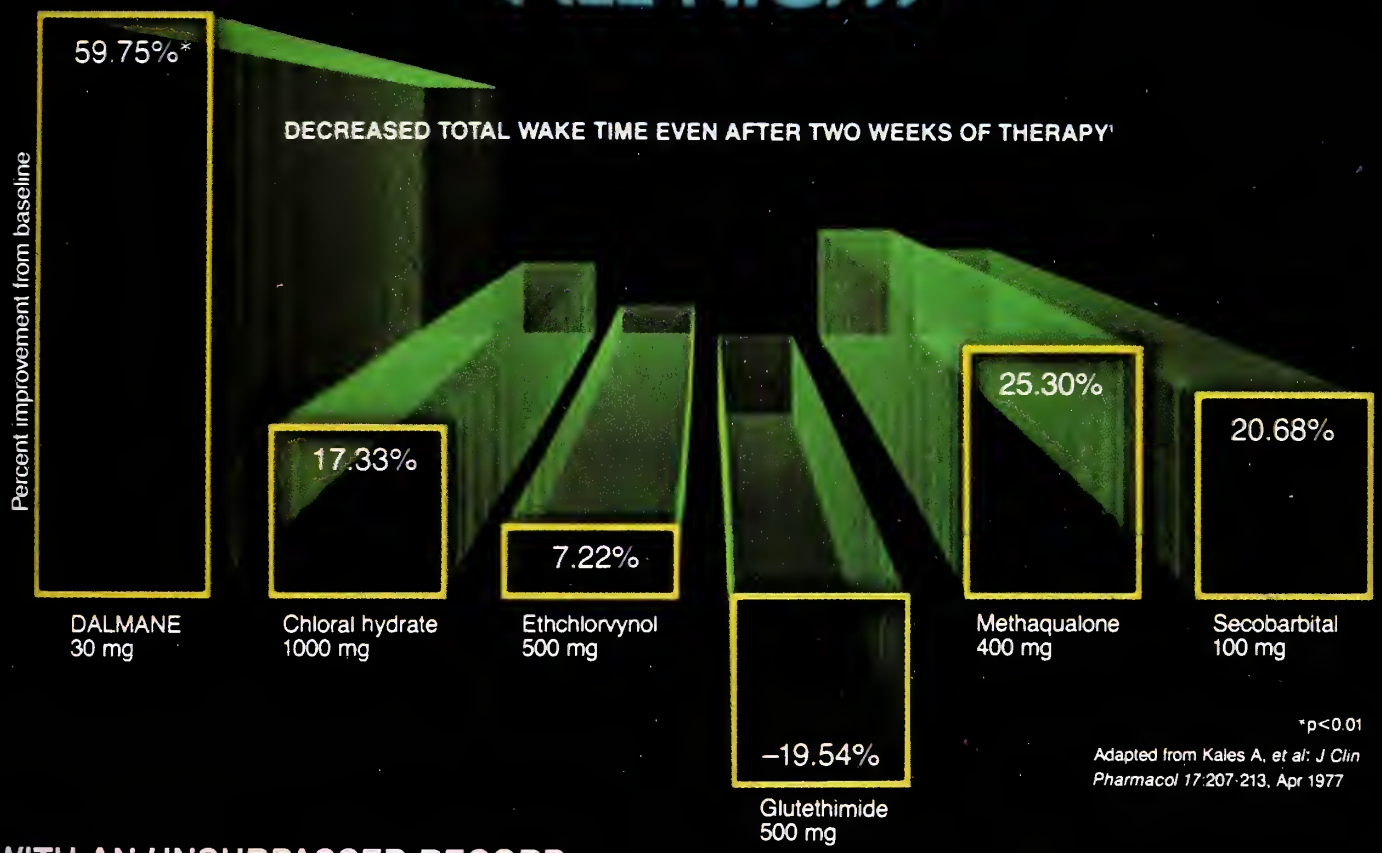
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–which may produce stimulation instead[11]

–which have anticholinergic effects[11]

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–where tolerance for sedation appears rapidly[12]

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.[4]

References: 1. Kales A, *et al*: *J Clin Pharmacol* 17:207-213, Apr 1977 **2.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977 **4.** Kales A, *et al*: *Clin Pharmacol Ther* 18:356-363, Sep 1975 **5.** Moore JD, Weissman L: *J Clin Pharmacol* 16:241-244, May-Jun 1976 **6.** Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **7.** Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, pp. 641-646 **8.** Warfarin Study: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **9.** Baldessarini RJ: Drugs and the treatment of psychiatric disorders, chap. 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp. 391-447 **10.** Cole JO, Davis JM: Antidepressant drugs, chap. 31.2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1941-1956 **11.** Douglas WW: Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap. 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp. 609-646 **12.** Davis JM, Cole JO: Antipsychotic drugs, chap 31.1, in *Comprehensive Textbook of Psychiatry/II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
Adults: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

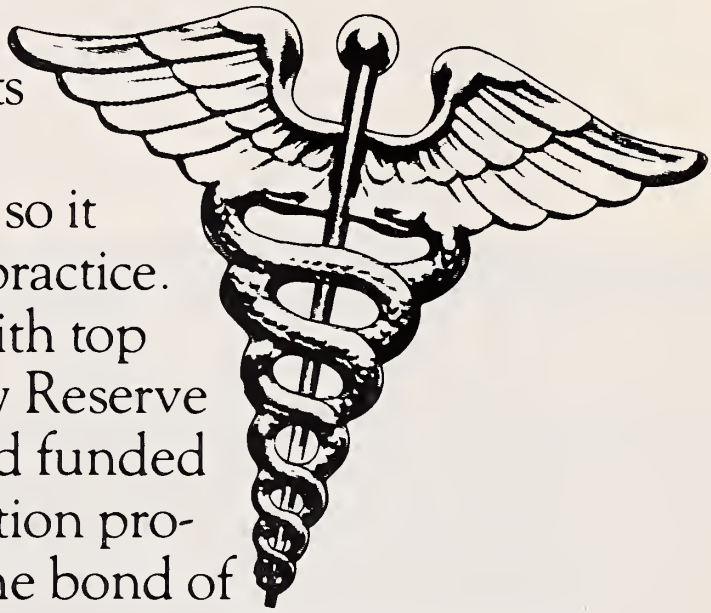
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editorial
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Reflections of a Country G.P.

While reflecting on the quality of general medical care provided by the private practitioner, I have closely examined the treatment I render to patients with diabetes mellitus. This is a disease much deserving of our time and attention, for epidemiologists estimate 10 million Americans have diabetes mellitus, making it one of the most widespread chronic diseases. Inasmuch as the majority of patients with diabetes are treated by physicians in private practice, the private sector should provide effective care at an acceptable cost. Failure to meet this responsibility invites bureaucratic intrusion.

Let us address the following questions: Is traditional protocol satisfactory for controlling diabetes? What improvements can and should be made?

With respect to my own practice, some patients are easily controlled, while an unacceptable number remain uncontrolled, no matter what measures we use. A few of these uncontrolled patients are juvenile diabetics; however, the majority are adults with maturity onset diabetes whose blood sugars are never normal.

Once the physician has made the diagnosis of diabetes mellitus and has prescribed the proper medical and dietary regimen, why do so many patients not assist us in their treatment? Illiteracy, functional or otherwise, plays a major role, as does both rural and urban poverty. Obviously, there are other reasons, including emotional problems, work schedules, and the pressures of daily living. With each diabetic, there is a unique story. In that story may lie the secret to proper management for that particular individual, but the secret is not often easily found.

Is there a solution for the uncontrolled diabetic?

One possible solution is the specialized diabetic education and motivation programs available in large cities. Those patients in my practice who could afford this type of private instruction were referred to these programs, and for the most part, were able to achieve better control. But the majority of patients in a rural practice cannot afford such a solution.

Another alternative is to offer "one-on-one" instructional programs in my office. However, to hire and maintain the necessary staff and to purchase the required equipment for adequate instruction has not been feasible in my practice.

In an effort to devise a better protocol for the management of diabetics and a delivery system which would be economically sound, the Southeastern Institute of Primary Care, a non-profit foundation under the direction of Mr. Gerald Hummel, evolved a plan to establish diabetic clinics to assist private physicians. In our area, a clinic for family medicine was established in Franklin. One of the clinic's functions is to provide routine care to patients with diabetes through the use of physician extenders such as physician's assistants and nurse practitioners. The attending physician prescribes the overall management regimen. The clinics provide patients with routine follow up and detailed instructions in dietary and medical matters. The result has been better management and greater patient compliance owing to an increased availability and convenience of medical care, with a reduction in overall patient cost.

I am convinced that the treatment of diabetes across the country would improve with the expansion of efforts such as these. It has been clearly shown that spreading the responsibility of health care to include the use of physician extenders in an environment like that of the clinic in Franklin does not compromise the quality of health care provided, nor does it infringe upon the role of the physician. On the contrary, it actually provides better health care to patients in need.

If we as private practitioners are to curb the advance of medical socialism, we must be ever alert to identifying deficiencies in the private health care system. We must be willing to make the sacrifice of time and energy necessary to find solutions to the problems of less than adequate medical care programs.

Jack E. Birge, M.D.
General Practice
Carrollton, GA

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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THE MULTIVITAMIN/MINERAL FORMULATION

president's letter



"Electronic" Rounds — A Future Reality?

THE HISTORIC JANUARY snowstorm produced a lot of unusual conditions in our state. Among other things, it gave me pause to consider how things could develop in the near future. I happened to be "covering" for two of my partners who were out of town when the paralyzing white blanket descended on Atlanta. Rounds needed to be made in multiple hospitals but became impossible under the conditions that were soon present.

At the outset, I had plenty of time to observe the weather and my fellow man as I spent 7 hours driving very slowly towards home. The CB was full of lively chatter, with pleas for help and occasionally useful information. Finally, with negligible progress having been made, a low fuel supply, and earnest hunger pangs, I jogged the remaining 5 miles home and warmed myself at the fireside.

It then became necessary to depend on only telephone communication for some hospital rounds as well as nearly all outpatient contact over the next several days. Although multiple attempts were often necessary, phone contact could be established and reasonably satisfactory rounds could be made by talking to patients, their family members, and the nurses. At least one-way ambulance service was available to bring patients to the hospital when necessary. For the most part patients were admitted to the hospital once they arrived, since there was usually no way for them to return home.

As these conditions persisted over several days, I began to catch a glimpse of what could be done with available technology and could imagine being able to conduct the electronic rounds of the future. With a computer and video and audio-communication between the physician and the patient, it seems that much data could be gathered, including a patient history and some examinations which could be carried out by the patient or a family member under the physician's observation. The physician would have access through his computer to the patient's history and current problems, medications, allergies, etc. Advice and instructions could be given by the physician via the patient's T.V. screen and could be taped for replay if necessary.

Such "electronic" rounds certainly are not with us yet, except under exceptional circumstances, but I would not be surprised if it does develop and become commonplace in the very near future.

Patient contact by electronic means certainly won't replace personal contact and the "laying on of hands," but I believe it can and will have many beneficial effects on the practice of medicine in the future.

L. Newton Turk III M.D.

L. Newton Turk, III, M.D.
President, M.A.G.

NEW MEMBERS

Bluestein, Barry M., DeKalb—ACT (N-2)—IM
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Bond, Robert K., Peachbelt—Service
USAF Hospital, Robins Air Force Base 31098

Bristol, William P., Bibb—ACT—PD
Mercer University School of Medicine, Macon 31207

Corker, Frank T., South Georgia—ACT (N-2)—OM
2704 N. Oak St., Valdosta 31601

Feldman, Daniel M., South Georgia—ACT (N-1)—PD
2000 N. Patterson St., Valdosta 31601

Garcia, Juan A., Richmond—ACT—IM
3922 Old Trail Rd., Martinez 30907

Helm, Steven G., Richmond—I&R—PD
MCG, Dept. of Pediatrics, Augusta 30907

Hilsman, Thomas A., Dougherty—ACT (N-2)—FP
Palmyra Park Emergency Room, 2000 Palmyra Rd., Albany 31701

Hirsch, Robert J., Cobb—ACT (N-2)—OBG
1230 Johnson Ferry Rd., Ste. D-10, Marietta 30062

McCain, Arthur J., DeKalb—I&R—R
Grady Memorial Hospital, Box 26357, 80 Butler St., SE, Atlanta 30303

Moseley, Thomas H., Jr., South Georgia—ACT (N-2)—OBG
Bldg. K, Oak Ctr., Valdosta 31601

Naidu, Subramanyam K., Clayton-Fayette—ACT (N-2)—IM
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Swann, R. Wade, Glynn—ACT (N-2)—D
3215 Shrine Rd., Brunswick 31520

Watkins, Lawrence O., Richmond—ACT—IM
MCG, Augusta 30912

PERSONALS

Third District

Robert B. Martin, III, M.D., of Cuthbert, announced his retirement in January of 1982 after 34 years of practicing general surgery in the community.

Fifth District

Edwin C. Evans, M.D., of Atlanta, was named President of the Southern Medical Association at their recent annual meeting in New Orleans. Dr. Evans is an internist in private practice and a clinical professor of medicine at Emory Univeristy's School of Medicine. He is a Fellow of the American College of Physicians.

Last January, **Mark A. Gould, M.D.,** Medical Director of Brawner Psychiatric Institute and Psychiatric Institute of Atlanta, was installed as President of the National Association of Private Psychiatric Hospitals (NAPPH). The NAPPH is a nonprofit organization of 190 free-standing, private psychiatric hospitals for the improvement of psychiatric hospital treatment and advancement of professional education in psychiatry, hospital administration and allied fields.



Mark A. Gould, M.D.

Harold P. McDonald, Jr., M.D., an Atlanta urologist at the Southern Foundation for Education and Medical Research, uses a new technique for prostate gland surgery that considerably reduces associated pain, risks, and costs. Though this technique is new to many urologists Dr. McDonald reports that in the 10 years he has used the "new" technique, a patient's hospital stay has been cut from 21 days to 5 days or less, and expenses are reduced by half. Dr. McDonald is among the 1% of urologists in the nation using this technique.

Ralph G. Newton, Jr., M.D., of Macon, was named a member of the Board of Governors of the Hospital Corporation of America (HCA) recently. He is past president of the Georgia Urological Association and a member of the American Urological Association and the AMA.

J. Roy Rowland, Jr., M.D., of Dublin, was unanimously endorsed by the Laurens County Medical Society in his bid for the U.S. House of Representatives. Dr. Rowland is presently serving a third term in the Georgia House of Representatives.

President and Dean of Morehouse College School of Medicine, **Louis W. Sullivan, M.D.,** was recently given a Certificate of Distinguished Service by the Medical Association of Atlanta. Dr. Sullivan was honored for his dedication and service to the community, and his leadership role in developing the first predominantly black medical school in this century.

Seventh District

Isben S. Giddens, M.D., of Lakeland, retired from active practice last December at the age of 72. Dr. Giddens' practice spanned 50 years. Many Lanier County residents speak of him fondly as "like a grandfather to everybody here."

Last January, **Charles H. Herndon, Jr., M.D.,** was inducted as a Fellow of the American Academy of Orthopaedic Surgeons.

Eighth District

For 5 weeks last summer, **Cleveland Thompson, III, M.D.,** and Mrs. Thompson, a registered nurse, worked in the Israeli-occupied Gaza strip at the Southern Baptist Mission Hospital.

Tenth District

Arlie R. Mansberger, Jr., M.D., MCG professor and chairman of the Department of Surgery, delivered the keynote address at the MCG emergency medical technicians' graduation ceremony last January.

James B. Craig, M.D., a Milledgeville psychiatrist, and Director of DHR's Medical Services for the division of mental health, is supporting a move for improvements in the "art of medicine." He was featured in an article in the Atlanta *Journal* which quoted from his paper published in the December *Journal of the MAG* entitled, "Windowless Pain." In it, he describes his experience as a patient. Because of this experience, he feels that the art of medicine and meeting patients' emotional needs is not being addressed by various groups, and that more changes are needed in hospital intensive care units.

DEATHS

Daniel Claude Kelley, Sr.

Daniel Claude Kelley, Sr., M.D., at the age of 94, died in January. After graduating in 1910 from the University of Nashville Medical School, Dr. Kelley began practicing medicine in Lawrenceville and was active until his retirement in the 60's.

Survivors include five children and one brother.

Frederick E. McLendon

Frederick E. McLendon, M.D., of Atlanta, died December 17 at the age of 75. Dr. McLendon, a native of Washington, Ga., graduated from Morehouse College and Meharry Medical College. He was a member of the MAG and AMA.

Dr. McLendon is survived by his wife, one daughter, two sons, one sister, and one brother.

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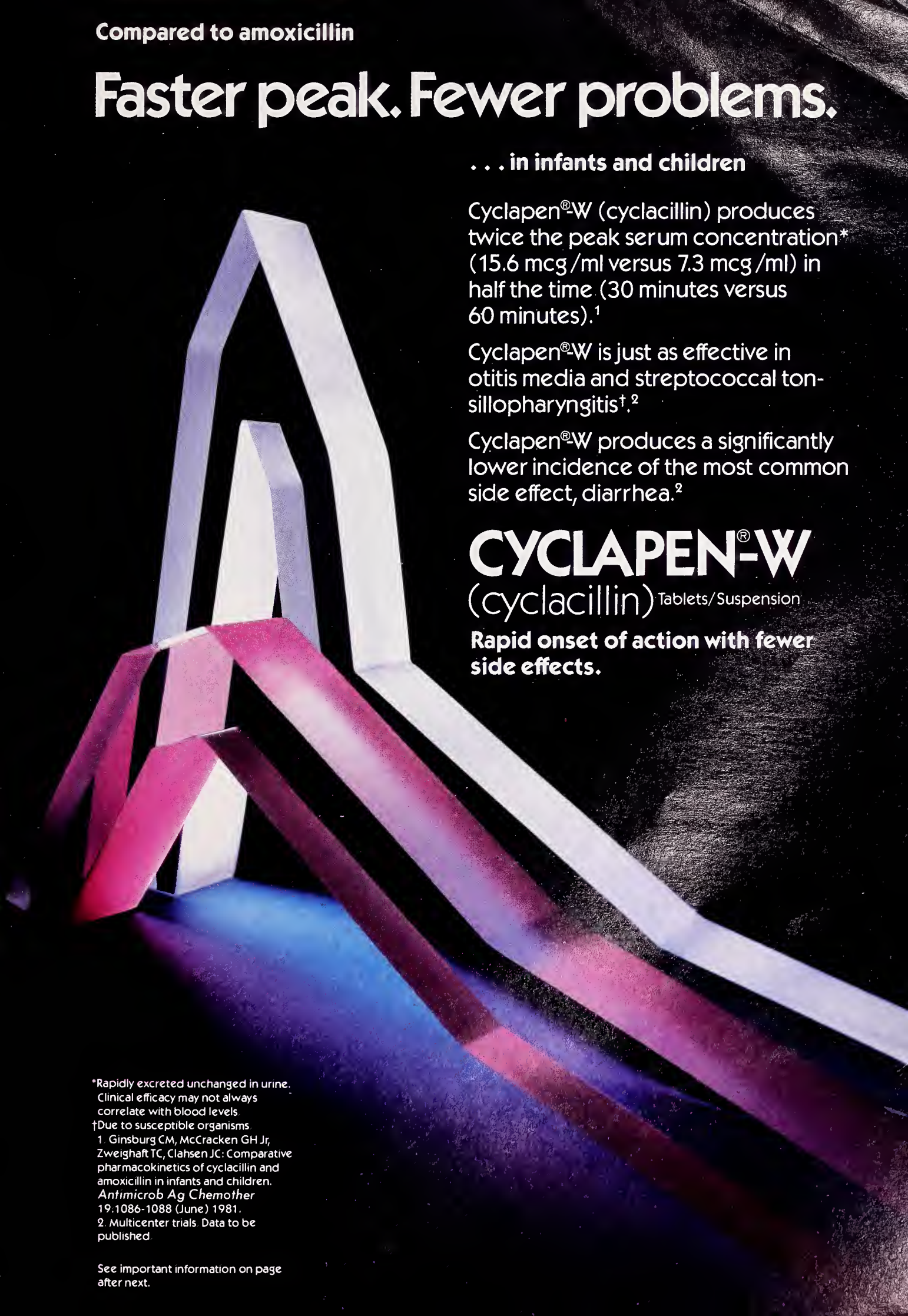
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1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.
2. Multicenter trials. Data to be published.

See important information on page after next.

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3. Data on file, Wyeth Laboratories.

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See important information on adjoining page.

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Cyclapen®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

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Bronchitis and pneumonia caused by S. pneumoniae (formerly *D. pneumoniae*)
Otitis media caused by S. pneumoniae (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

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As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus,* 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes,* and 1% beta-hemolytic *Streptococcus*.‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGDT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

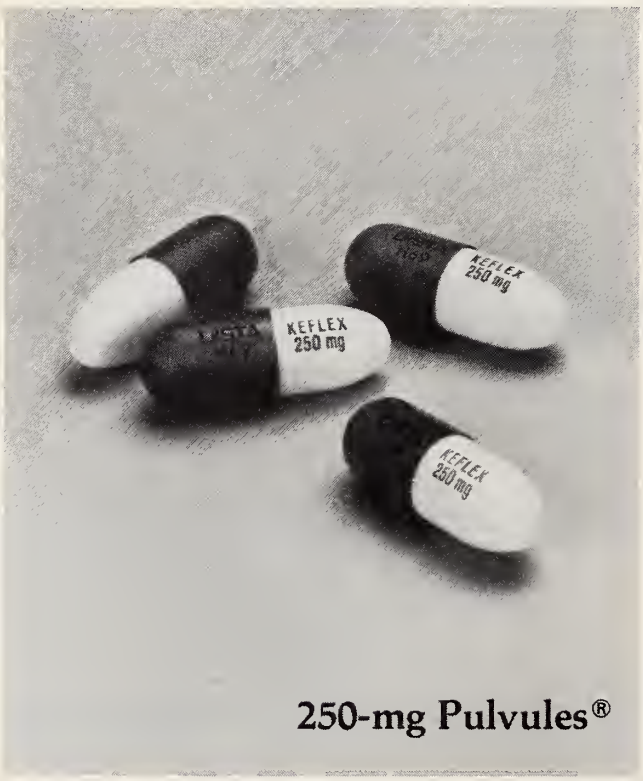
N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:
Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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Such problems as alcoholism, drug addiction, adult, adolescent and child psychiatric troubles are discussed in this free brochure. It explains, in depth, Peachford Hospital's uniquely positive, comprehensive program of recovery... that's working!

Peachford is a full-service 204-bed psychiatric hospital, providing short, intermediate and long-term treatment programs for adults, children and adolescents. Hospital care is available to all patients regardless of the severity of their illness or of complicating addictions or medical problems.

Programs

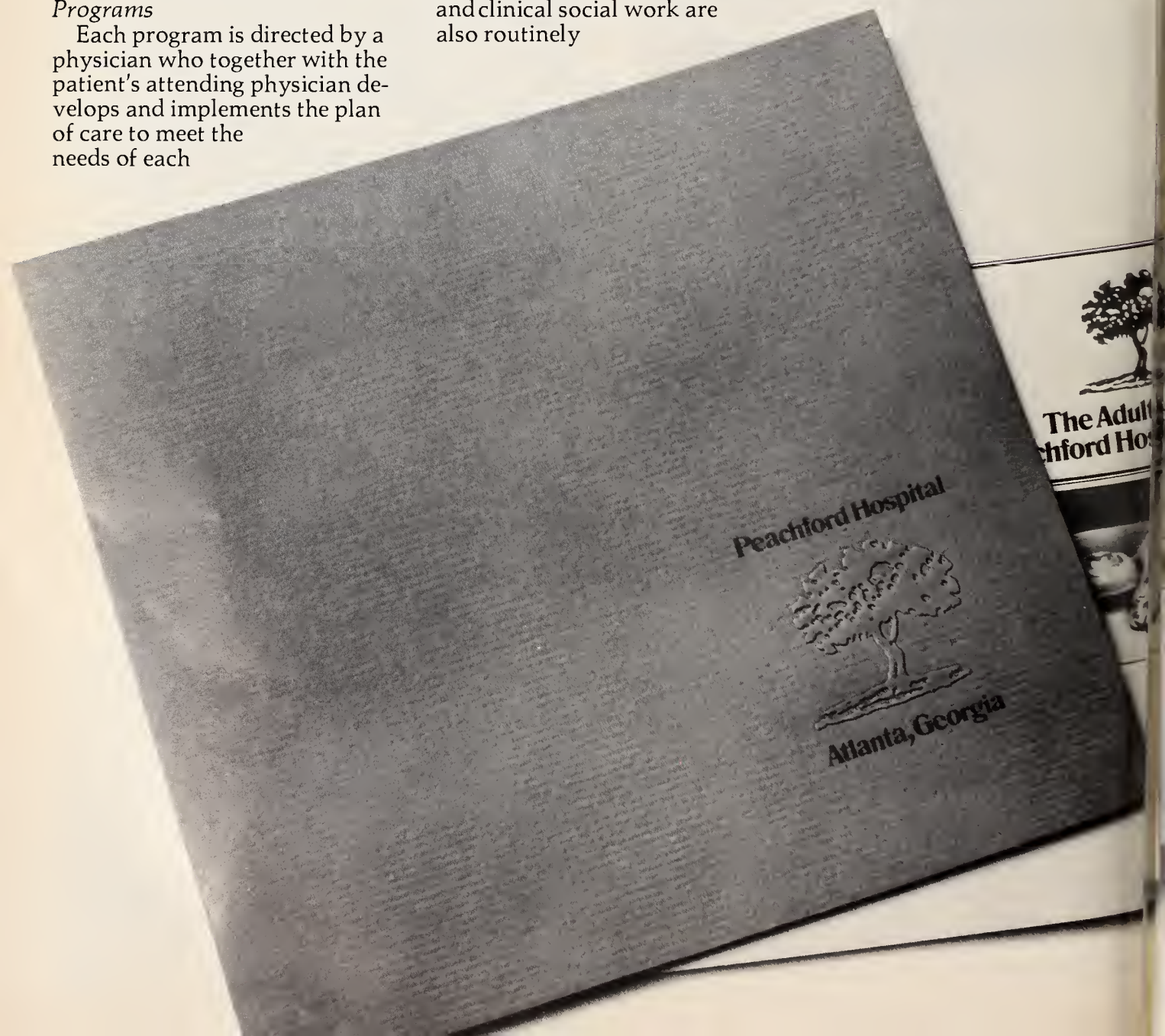
Each program is directed by a physician who together with the patient's attending physician develops and implements the plan of care to meet the needs of each patient on an individualized basis.

Adult Psychiatric Program — provides a structured therapeutic milieu approach with multiple teams of up to 13 patients each for individuals 18 years of age and older. Individual and group therapies are conducted daily, with activities therapy and clinical social work services scheduled throughout the week.

Young Adult Program — a unique, innovative program specifically designed for the young adult patients ages 18-25. Therapy on a group as well as an individual basis is provided daily. Activities therapy and clinical social work are also routinely conducted throughout the week.

Adolescent Psychiatric Progra consists of treatment units of 16 patients each between the ages o and 17. All adolescent patients pa ticipate in individual, family, and group therapy sessions, some da and some scheduled throughout week. Educational needs are met an individualized basis in an org ized classroom setting. Parents o the patients meet together weekl in group sessions to discuss common issues and concerns.

Child Psychiatric Program — designed as a 12 patient unit and



rious problems.

ovides individualized services for ildren between the ages of 4 and . The structured daily program r all children includes individual d group therapy sessions, as well individualized programs for edu- tion, activities therapy, develop- ental play, and social services. rt, dance, music, occupational, d recreation therapy are vital mponents of the program. rents are involved in family sessions and parents' groups.

Addictive Disease Program — includes detoxification, intermediate care, and aftercare services based on the philosophy of Alcoholics Anonymous. The treatment program is designed to focus on the total person through participation in educational lectures, group therapy, activities therapy, and family programs. The goal of the program is to teach the addicted individual a manner of living by which he or she may remain free of all addictive substances.

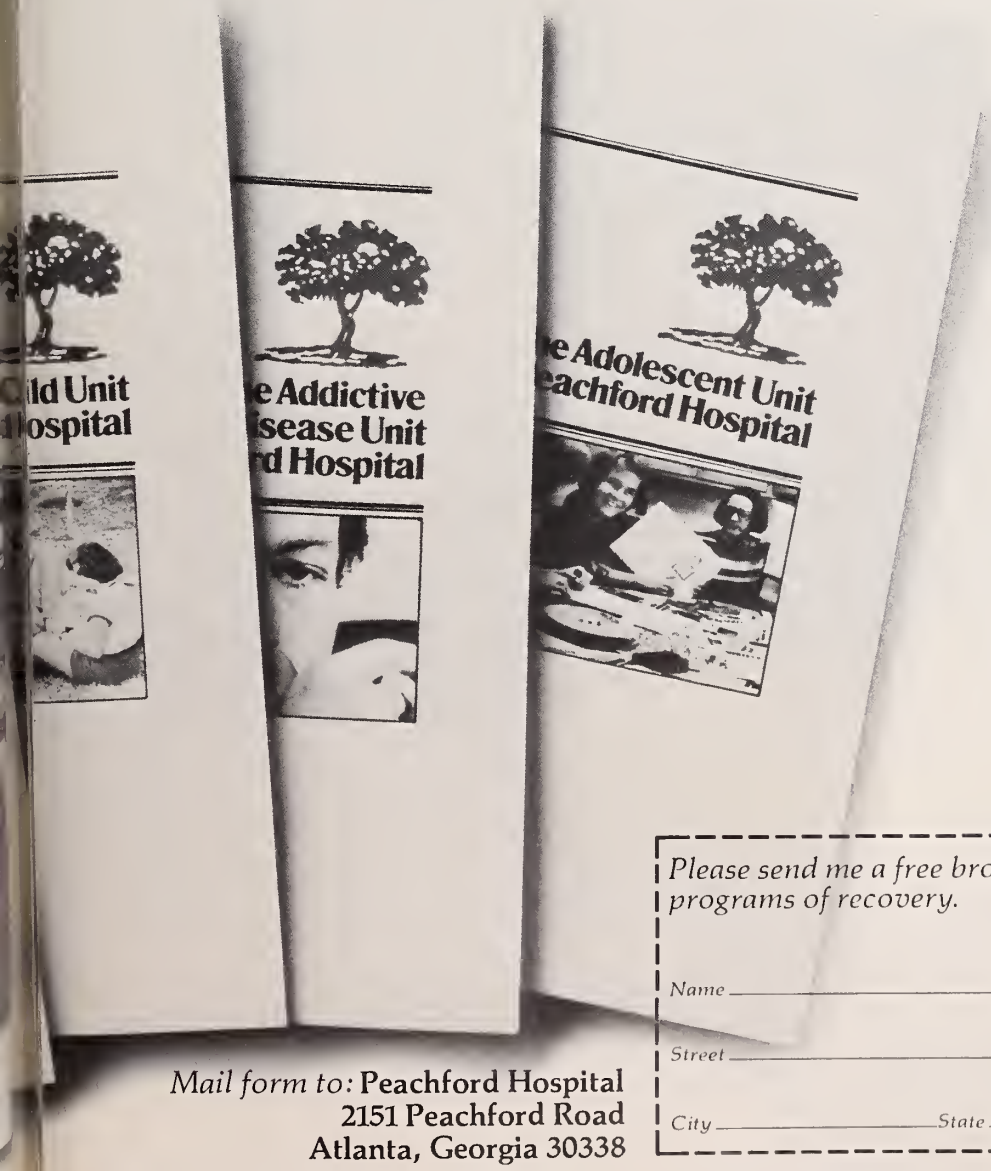
The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, art therapists, music therapists, dance therapists, teachers and counselors.

Physical Facilities — located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an x-ray department, a laboratory, emergency treatment rooms, auditorium, gymnasium, adolescent and children's schools, group therapy rooms, activities therapy rooms, year-round swimming pool, tennis courts, and athletic field for softball, football, volleyball, basketball and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

For your free brochure, or for a personal tour of the facilities and an explanation of the programs, please contact Peachford Hospital at (404) 455-3200, or use the order blank below.



Please send me a free brochure about Peachford Hospital's programs of recovery.

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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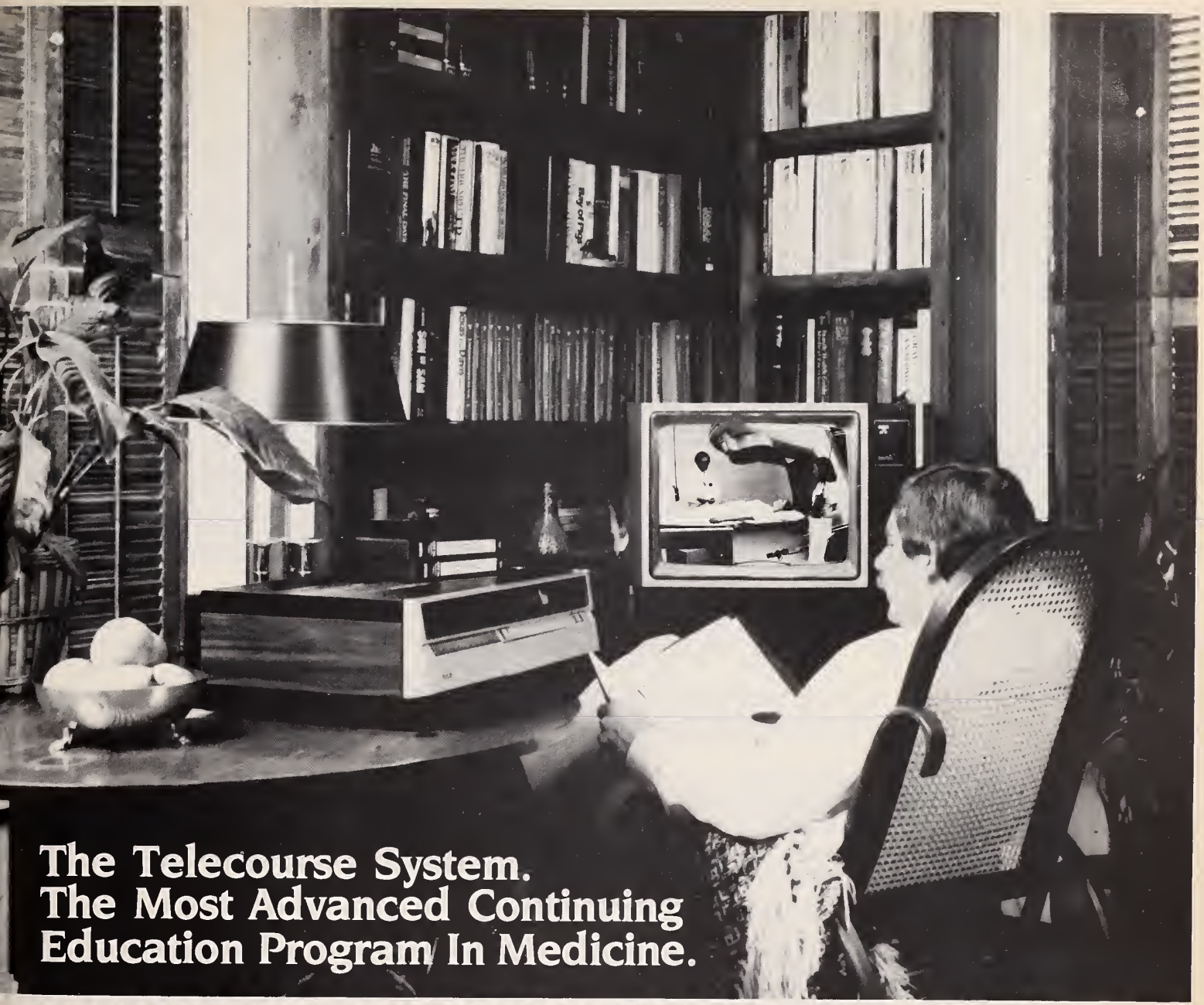
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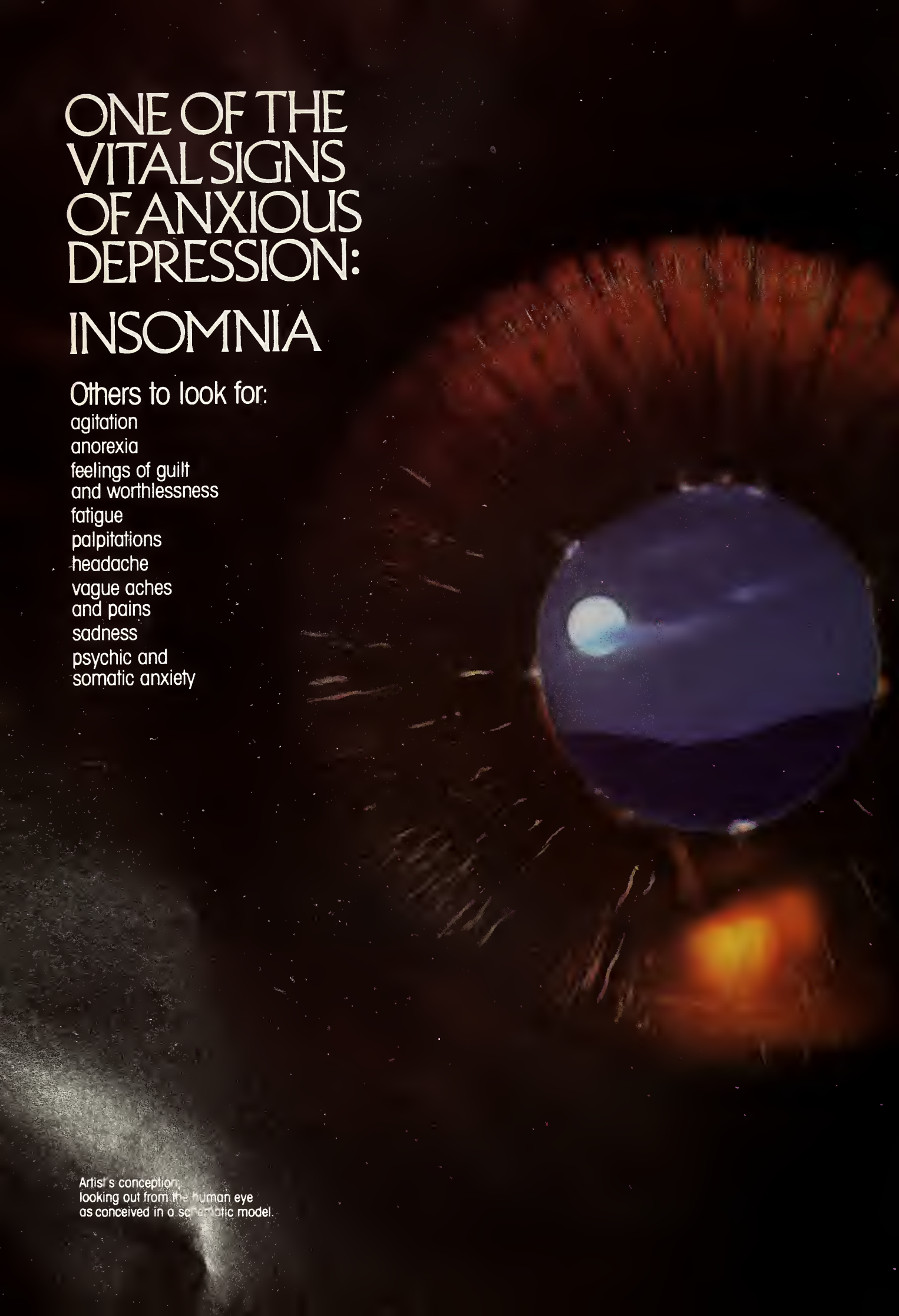
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ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION:

INSOMNIA

Others to look for:

agitation
anorexia
feelings of guilt and worthlessness
fatigue
palpitations
headache
vague aches and pains
sadness
psychic and somatic anxiety



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looking out from the human eye
as conceived in a schematic model.

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Wornings: Use with great core in potients with history of urinory retention or ongle-closure gloucomo. Severe constipotion may occur in potients toking tricyclic ontidepressonts ond onticholinergic-type drugs. Closely supervise cordiovoscular potients (Arrhythmios, sinus tochycordio ond prolongotion of conduction time reported with use of tricyclic ontidepressonts, especially high doses. Myocordiol infarction ond stroke reported with use of this closs of drugs.) Coution potients obout possible combined effects with olcohol ond other CNS depressonts ond ogoinst hozordous occupotions requiring complete mentol olertness (e.g., operoting mochinery, driving).
Usoge in Pregnoncy: **Use of minor tronquilizers during the first trimester should olmost olwoys be ovoided becouse of increosed risk of congenitol molformotions os suggested in severol studies. Consider possibility of pregnoncy when instituting theropy; odvise potients to discuss theropy if they intend to or do become pregnont.**
Since physicol ond psychological dependence to chlordiozepoxide have been reported rorely, use coution in administering Limbitrol to addiction-prone individuols or those who might increose dosoge; withdrowol symptoms following discontinuotion of either component olone have been reported (nouseo, heodoche ond moloise for omitriptyline; symptoms [including convulsions] similor to those of borbiturote withdrowol for chlordiozepoxide).
Precoutions: Use with coution in potients with o history of seizures, in hyperthyroid potients or those on thyroid medicotion, ond in potients with impoired renol or hepotic function. Becouse of the possibility of suicide in depressed potients, do not permit eosy occess to lorge quontities in these potients. Periodic liver function tests ond blood counts ore recommended during prolonged treotment. Amitriptyline component moy block oction of guonethidine or similor ontihypertensives. Concomitont use with other psychotropic drugs hos not been evoluoted: sedotive effects moy be odditive. Discontinue several doys before surgery. Limit concomitont odministrotion of ECT to essentiol treotment. See Wornings for precoutions obout pregnoncy. Limbitrol should not be token during the nursing period. Not recommended in children under 12. In the elderly ond debilitoted, limit to smollest effective dosoge to preclude otoxio, oversedotion, confusion or onticholinergic effects.
Adverse Reoctions: Most frequently reported ore those ossocioted with either component olone: drowsiness, dry mouth, constipotion, blurred vision, dizziness ond blooting. Less frequently occurring reoctions include vivid dreoms, impotence, tremor, confusion ond nosol congestion. Many depressive symptoms including onorexio, fotigue, weokness, restlessness ond lethorgy hove been reported os side effects of both Limbitrol ond omitriptyline. Gronulocytopenio, joundice ond hepotic dysfunction hove been observed rorely.
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Cordiovoscular: Hypotension, hypertension, tochycordio, polpitotions, myocordiol infarction, orrhythmios, heort block, stroke.
Psychiotric: Euphorio, opprehension, poor concentrotion, delusions, hollucinotions, hypomonio ond increosed or decreosed libido.
Neurologic: Incoordinotion, otoxio, numbness, tingling ond poresthesios of the extremities, extropyromidol symptoms, syncope, chonges in EEG potterns
Anticholinergic: Disturbonce of occommodotion, porolytic ileus, urinory retention, dilototion of urinory tract.
Allergic: Skin rosh, urticorio, photosensitizotion, edemo of foce ond tongue, pruritus.
Hemotologic: Bone morrow depression including ogronulocytosis, eosinophilio, purpuro, thrombocytopenio.
Gostrointestinol: Nouseo, epigostric distress, vomiting, onorexio, stomotitis, peculior toste, diorrhea, block tongue.
Endocrine: Testicular swelling ond gynecomostio in the mole, breost enlorgement, goloctorrhea ond minor menstruol irregulorities in the female and elevotion and lowering of blood sugor levels.
Other: Heodoche, weight goin or loss, increosed perspirotion, urinory frequency, mydriosis, joundice, olopecio, porotid swelling
Overdosoge: Immediotely hospitolize potient suspected of hoving token on overdose. Treotment is symptomotic ond supportive. I.V. odministrotion of 1 to 3 mg physostigmine solicylote has been reported to reverse the symptoms of omitriptyline poisoning. See complete product infarmotion for monifestotion ond treotment.
Dosoge: Individuolize according to symptom severity and potient responso. Reduce to smollest effective dosoge when satisfoctory response is obtained. Larger portion of doily dose moy be token ot bedtime. Single *h.s.* dose moy suffice for some potients. Lower dosoges ore recommended for the elderly. Limbitrol 10-25, initiol dosoge of three to four tablets doily in divided doses, increased to six tablets or decreased to two tablets doily os required. Limbitrol 5-12.5, initiol dosoge of three to four tablets doily in divided doses, for potients who do not tolerote higher doses.
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MEDICAL MEETING CALENDAR

APRIL

17-18—*Atlanta:* **Hemodynamic Monitoring.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-24—*Atlanta:* **Michael Hoke-Hiram Kite Program on Pediatric Orthopedics.** Category 1 credit. Contact Wood Lovell, M.D., 1001 Johnson Ferry Rd., NE, Atlanta 30363. PH:404/257-2045.

20-24—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

22—*Greenville, SC:* **Medical Care of the Aged Patient.** Category 1 and AAFP prescribed credits. Contact P. S. Snape, M.D., Center of Family Medicine, 701 Grove Rd., Greenville Hosp. System, Greenville, SC 29605. PH:803/242-7800.

23-24—*Atlanta:* **Arrhythmias and Cardiac Ischemia: Diagnosis and Management.** Category 1 and AAFP prescribed credit. Contact International Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

24-25—*Augusta:* **Disease Prevention and Health Maintenance.** AMA Category 1 and AAFP prescribed credit. Contact Gerald T. Chambers, Ph.D., Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

25-29—*Atlanta:* **31st Annual Scientific Session — American College of Cardiology.** Contact Meeting Services Dept., ACC, 9111 Old Georgetown Rd., Bethesda, MD 20814. PH:301/897-5400.

30-May 2—*Myrtle Beach, SC:* **Third National Conference on Emotional Stress and Cardiovascular Disease.** Category 1 credit. Contact Charles D. Troutman, Am. Heart Assn., S.C. Affil., P.O. Box 6604, Columbia, SC 29260. PH:803/738-9540.

MAY

2-5—*Sea Island:* **Annual Meeting of the Georgia Society of Ophthalmology.** Category 1 credit. Contact Talitha Russell, 938 Peachtree St., NE, Atlanta 30309. PH:876-7535 or 800/282-0224 (toll free in Ga.).

3-8—*Augusta:* **17th Annual Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

13-14—*Atlanta:* **Fifth Annual Course on Management of the Chronic Renal Disease Patient.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

13-15—*Atlanta:* **Annual Update in Pathology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

17-19—*Atlanta:* **Coronary Disease — 1982.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-21—*Atlanta:* **Eighth Annual Course on Techniques in Orthopaedic Surgery: Deformities of the Spine.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

20-21—*Callaway Gardens:* **Tenth Annual Perinatal Medicine Conference.** Category 1 credit and AAFP prescribed credit. Contact Micki L. Souma, MD, Chief, Dept. OB/GYN. Med. Ctr., P.O. Box 951, Columbus 31902. PH:404/324-4711.

21-22—*Atlanta:* **Update of Systemic Lupus Erythematosus: Current Concepts of Diagnosis and Treatment.** Category 1 credit. Contact Karen Crenshaw, West Paces Ferry Hosp., 3200 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-0351 x208.

JUNE

2-4—*Lexington, KY:* **Eleventh Update in Ob-Gyn.** Category 1 credit. Contact Frank P. Lemon, M.D., Cont. Ed., College of Med., Univ. of Kentucky, Lexington, KY 40536-0084. PH:606/233-5161.

3-5—*Atlanta:* **Clinical Topics in Gynecology & Obstetrics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta, 30322. PH:404/329-5696.

4-11—*Mississippi River Cruise:* **Cardiology for the Practitioner.** Category 1 credit. Contact Univ. of Fla. College of Med., Box J233, JHM Health Ctr., Gainesville, FL 32610. PH:904/392-3143.

14-16—*Kiawah Island, SC:* **Recent Advances in Internal Medicine.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

25-27—*Hilton Head, SC:* **Pulmonary Manifestations of Systemic Disease.** Category 1 credit. Contact Amer. College of Chest Physicians, Dept. of Ed., 911 Busse Highway, Park Ridge, IL 60068.

JULY

24-25—*Kiawah Island, SC:* **Cardiac and Pulmonary Critical Care Medicine.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

26-28—*Kiawah Island, SC:* **Pediatric Update — 1982.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-31—*Hilton Head Island:* **Fifth Annual Symposium on Contemporary Clinical Neurology.** Contact Mrs. Joan Sullivan, Dept. of Neurology, Vanderbilt Univ. Sch. of Med., Nashville, TN 37212. PH/615-322-3461.

AUGUST

2-6—*Hilton Head Island:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

9-11—*Kiawah Island, SC:* **Clinical Obstetrics.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

15-20—*Atlanta:* **Internal Medical Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

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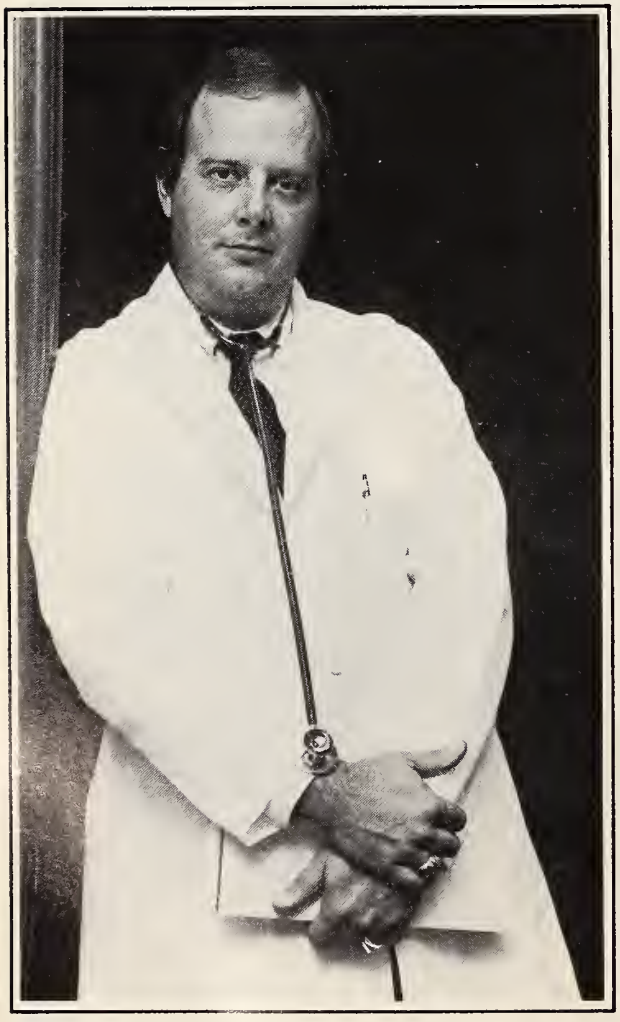
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Letter to the Editor . . .

Comments from MAG Member Concerning the 1982 AMA Leadership Meeting

Dear Sir:

The 1982 annual meeting of the AMA Leadership Conference was themed "A New Beginning." This referred to the quote by President Reagan about his fiscal and budgetary changes from previous administrations as they relate to health care. The AMA program went into an in depth study about the "medical economics" of the 1980s. This period will be different than anything we have already known. Our medical technology has progressed at a faster rate than the available dollar supply can pay for. The population of our country is increasing, as is the number of people living longer. The demands for newer and larger services is trying to be met by the health "industry" (doctors, hospitals, nursing homes). When you add the factors of growth and expense into a slowing economy with a vital need for national defense, then by simple mathematics you simply *run out of money*. At the 2-day meeting, we found out how to suggest altering the financial formulas so that we do not go further into the financial hole, or worse, go bankrupt. This is a serious problem.

When I was a child, there were many things I did without. My family just said no, and I accepted it. We have tried at home to say no to our children to the many extravagances that we could not afford. This is what is going to have to happen in the field of medicine. The person with an unlimited "credit card" insurance policy is going to have to restrain usage just to keep his premium in line with the services he really needs. A visit to the doctor and the hospital is not a visit to a candy store. The *third party payers* (insurance, Medicaid, and Medicare) will have to offer restrained, sensible, needed programs that would cover catastrophic and serious illness. The hospitals will have to become price competitive; its labor force will have to make themselves eager to help sick people. Hospitals will have to provide services economically and fairly. As doctors, we will have to change a great deal, too!

The practice of medicine in the 1980s will be in a *competitive* atmosphere. The consumer will have choices. The para-health folks, nutritionists, physical cultists, chiropractors, etc. are competing for the health care dollar. The Reagan policy of returning health care to the "market place" rather than supporting an elite cottage industry with protections is one of the key points in this message. The physician by necessity will have to compete like never before. We physicians will have to make "coalitions" with the providers of the health care dollars. For example: third party payers' private health insurance provides 35% of the money going into the health care system. We need to help them help their clients make *good choices*. There are many powers out there not making or wanting good choices. This is one of the serious problems. The U.S. Department of Health and Human Services will be spending billions on its health programs. As physicians, we need to *responsibly* advise them.

We cannot afford to be complacent. We need to speak up. We need to regulate ourselves. The philosophy of "everything offered in medicine to everyone" and "every test and procedure for every likely candidate" must go. The "procedure" doctor will need to be highly selective and not become a procedure "mill" physician. These doctors make indefensibly large incomes. How can I in a primary care position justify this imperial wealth? My fellow members, I cannot do it. I can no more justify a sick child going to a $30 emergency room, having a $30 emergency room physician, receiving $60 in tests, and coming out with a $120 virus than I can justify coronary testing on 80-year-olds who can't get out of bed.

This is what is coming in the '80s. The key words will be "coalition, competition, market place, proper medicine, self regulation, private sector, New Dynamics, voluntarism, New Federalism, and initiative."

Sincerely,
Marvyn D. Cohen, M.D.
President,
Muscogee County Medical Society

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INDICATIONS AND USAGE SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

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Mitral Valve Prolapse in Private Practice — Analysis of 100 Cases

JOHN D. CANTWELL, M.D., *Atlanta**

MITRAL VALVE prolapse (MVP) is one of the most commonly encountered cardiac conditions in private practice. It is also frequently overlooked and often misdiagnosed. The purpose of this report is to describe the prevalence of this condition in a survey of 100 employees and spouses of an Atlanta corporation and to analyze 100 cases of MVP seen by the author, emphasizing the spectrum of clinical symptoms and signs.

Prevalence in Presumably Healthy People

I performed cardiac examinations and exercise tests on 100 employees and spouses of a local corporation. None of the subjects gave any history of cardiac disease or known auscultatory abnormalities. Of 45 men, two (4.4%) had isolated midsystolic clicks. Of 55 women, 14.5% had evidence of the syndrome (half with isolated nonejection clicks and half with a click-murmur). These findings are compared with those in other population groups (Table 1).

Analysis of 100 Cases

Of 100 patients with MVP seen in my private practice, 50 were men and 50 were women. The syndrome would seem more prevalent in the latter, since 85% of my patient population is male. The age range was 17-77 (average 41.4 years). The clinical symptoms are listed in Table 2. Palpitations were the most common complaints, seen alone or in conjunction with chest pain in 39% of cases. A total of 34% of the cases were asymptomatic, and 27% had chest pain.

TABLE 1 — Three Patient Populations with Varying Symptoms of Mitral Valve Prolapse

Patient Population	*Number*	*Click*	*Click-Murmur*	*Murmur*
Newborn Girls[1]	100	3%	4%	0
Male Medical Personnel[2]	107	4%	7%	0
Corporate Employees and Spouses	100	6%	4%	0

TABLE 2 — Clinical Symptoms of Mitral Valve Prolapse in 100 Patients in a Private Practice, Atlanta, GA

Symptoms	*Percent*
Palpitations Only	22
Chest Pain Only	17
Palpitations and Chest Pain	10
Chronic Headaches	5
Dyspnea	4
Anxiety/Panic Attacks	3
Syncope	2
Dizziness	1
Lethargy	1
Awareness of Sound in Chest	1
Asymptomatic	34

The cardiac examination revealed an isolated midsystolic click in 64%. A click-murmur was heard in 31% and an isolated mid-to-late systolic murmur in 5%. Three percent of the late systolic murmurs became pansystolic on follow up, perhaps due to ruptured chordae tendinae or to progressive myxomatous degenerative changes of the valve.[3]

Two patients had tenting of fingerprints on multiple digits.[4] This clinical sign was not meticulously searched for in all cases, however.

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TABLE 3 — Normal and Abnormal Resting ECGs of 100 Patients in a Private Practice, Atlanta, GA

ECG Results	*Percent*
Normal	82
Abnormal	18
• QRS Axis Deviation	6
LAD	4
RAD	2
• ST-T Abnormalities	3
• Old Myocardial Infarction	3
• Atrial Fibrillation	2
• Short P-R Interval	2
• Sinus Tachycardia	1
• Intraventricular Conduction Delay	1

TABLE 4 — Abnormalities Associated with Exercise Testing in 86 Private Practice Patients, Atlanta, GA

Abnormality	*Number*
Ventricular Ectopy	12
Supraventricular Ectopy	6
Ventricular and Supraventricular Ectopy	3
ST-Segment Depression	5

All patients had resting electrocardiograms (ECGs). These were abnormal in 18% (Table 3). Exercise testing was done in 86 cases. Twenty-six of the latter were abnormal, mostly due to rhythm disturbances (Table 4). Depression of the ST-segment was seen in five instances, surprisingly low considering prior reports of frequent false-positive tests in this patient population.[5] One of the five occurred in a patient with well-documented coronary disease. Another was shown to be a false-positive test, in view of a normal coronary angiogram.

Selected Case Studies

The mitral valve prolapse syndrome encompasses a wide variety of symptoms and clinical presentations, a few examples of which are described below:

Case #1 — Dyspnea, Chest Pain, Panic Attacks[6]

A 42-year-old woman noted symptoms of nonexertional dyspnea which would frequently awaken her from sleep. She also experienced mid-chest pressure sensations, radiating to the left arm and lasting an hour or more. She became extremely anxious during these episodes, anticipating a cardiac catastrophe. A previous physician had diagnosed angina pectoris.

On physical examination she had multiple mid-systolic clicks (Figure 1). She was treated with a low dose (40 mg/day) of propranolol during exacerbations of her symptoms and has done well over a 7-year follow-up period.

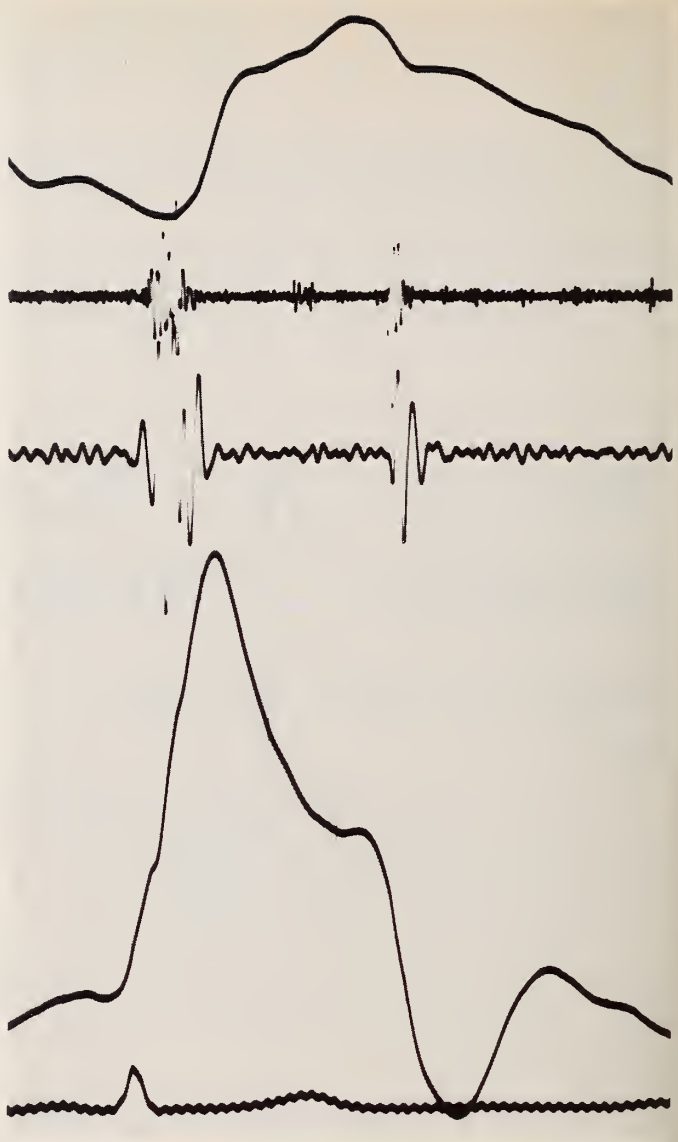


Figure 1 — Midsystolic click recorded in Case #1.

Case #2 — Bradycardia-Tachycardia Syndrome

A 58-year-old woman was referred because of palpitations. In addition to the episodes of tachycardia, she complained of chest pain, dizziness, and lethargy. Her blood pressure was 88/60 mm Hg. Double mid-systolic clicks were heard at the cardiac apex, followed by a late systolic murmur. Holter monitoring showed episodes of atrial fibrillation, interspersed with periods of sinus bradycardia. When medical therapy failed to relieve her symptoms, a permanent pacemaker was implanted and digitalis and propranolol were prescribed. Her arrhythmias have been well controlled on this regimen, but she continues to have mild episodes of lethargy and chest pain.

Case #3 — Syncope and Tachycardia

A 59-year-old woman had episodes of rapid heart action and syncope, dating back to age 14. She had

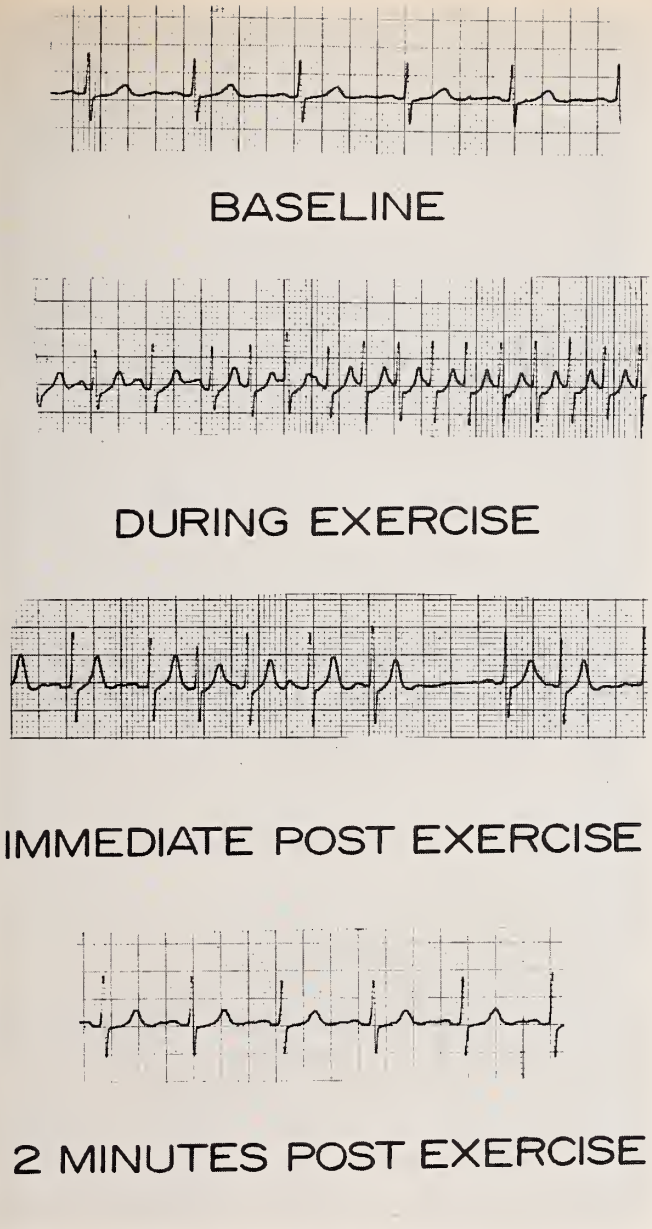


Figure 2 — Supraventricular tachyarrhythmia during exercise testing in Case #3.

been given quinidine sulfate, without apparent benefit. A systolic heart murmur had recently been noted.

Cardiac examination revealed a midsystolic click and late systolic murmur. Treadmill exercise testing reproduced her symptoms of tachycardia and near-syncope (Figure 2). A supraventricular tachyarrhythmia was recorded and reverted spontaneously to sinus rhythm. She was treated with propranolol, with initial success.

Case #4 — Anginal Pain and Ischemia on Exercise Testing

A 59-year-old man was seen elsewhere for a routine examination, found to have ST-segment depression on exercise testing, and advised to have coronary angiography. He requested a second opinion.

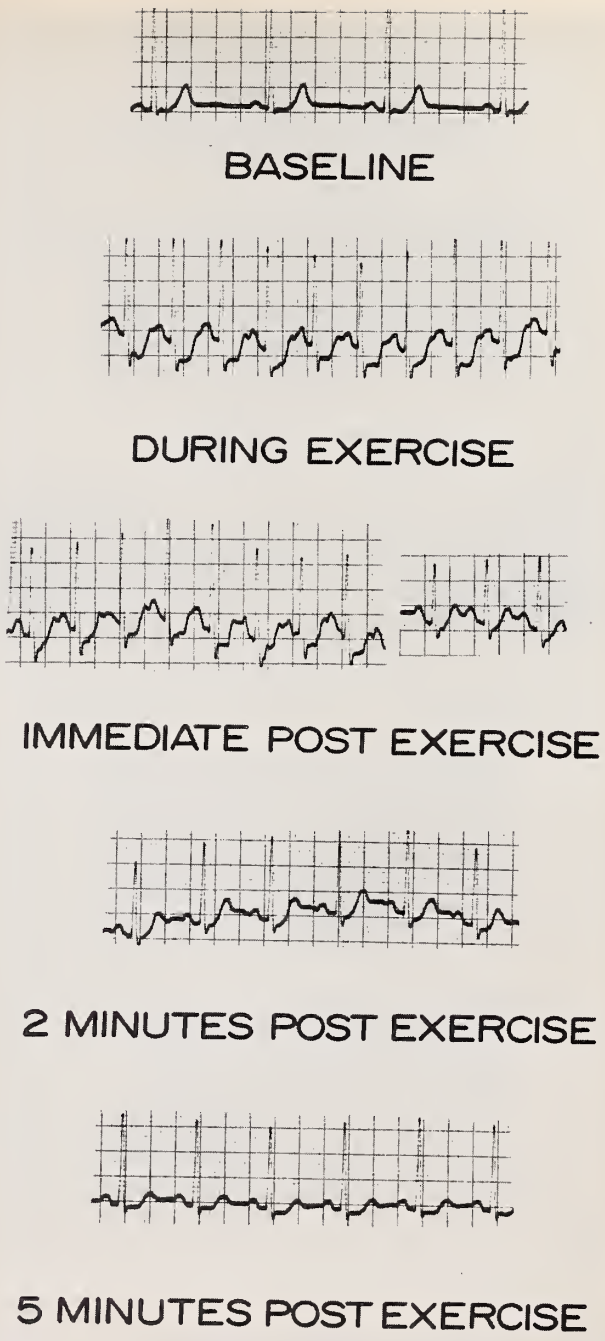


Figure 3 — False-positive exercise ECG in Case #4.

On my medical history, he recalled three episodes of mild substernal burning chest pain associated with jogging. This was an inconsistent symptom, however, and he could frequently jog longer distances without pain. A midsystolic click was noted on cardiac auscultation. His resting ECG showed nonspecific ST-segment variations. He developed an additional 3mm of ST-segment depression on treadmill exercise testing (Figure 3). In view of this finding, his chest pain, and his desire to continue with vigorous exercise, I concurred with the angiogram, which was normal.

Case #5 — High-Grade Ventricular Ectopy

A 61-year-old man had a 9-year history of symptomatic ventricular premature beats, including short

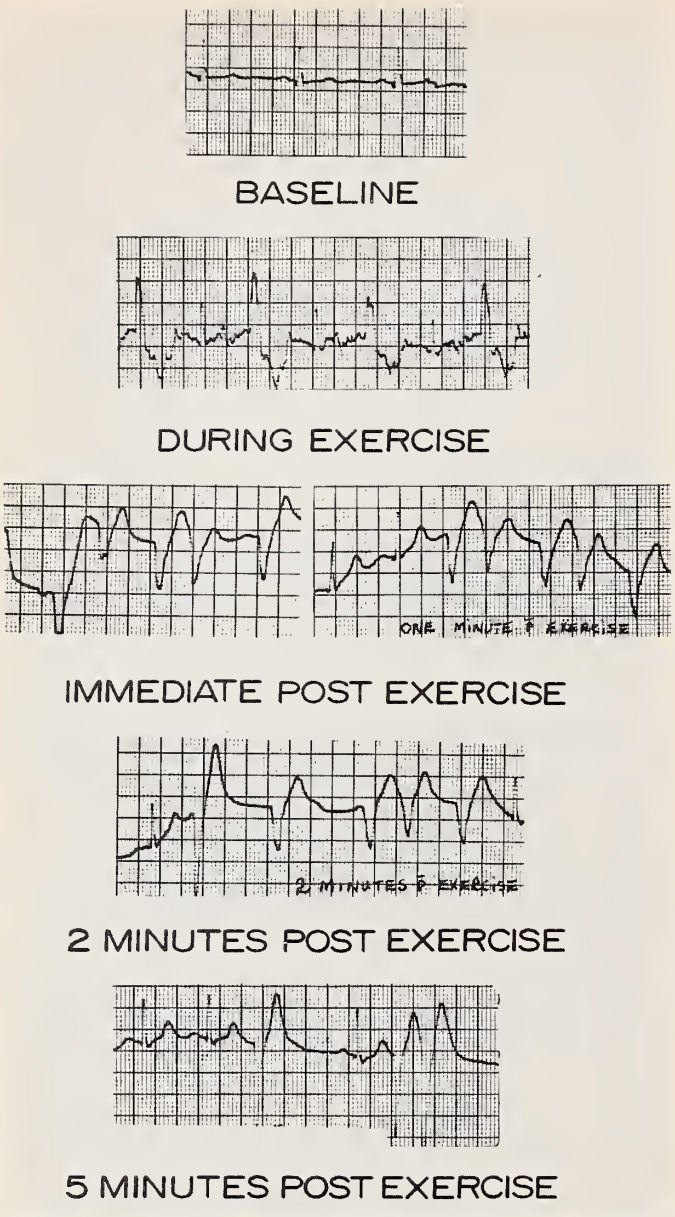


Figure 4 — Ventricular tachycardia during exercise testing on Case #5.

runs of ventricular tachycardia (Figure 4) on exercise testing. He was currently taking digoxin and metoprolol and had been receiving diphenylhydantoin, procainamide, and propranolol. Cardiac catheterization had been performed 2 years previously due to the ventricular ectopy and showed normal coronary arteries and left ventricular function.

My examination revealed a grade 3/6 pansystolic murmur at the cardiac apex, a change from the previous description of a mid-to-late systolic murmur. I advised hospitalization for acute drug testing, even though his ectopy was of a chronic nature. The patient chose to defer this, citing a pressing obligation to his church. In the meantime, quinidine sulfate had been started by his referring physician and with my approval. The patient died suddenly 5 days later.

Discussion

Gallavardin[7] described a systolic nonejection click and late systolic murmur in 1913 and attributed it to pleuropericardial adhesions. Fifty years later, Barlow[8] showed on angiography that late systolic prolapse of the posterior mitral leaflet, with resultant mitral regurgitation, best explained the clinical findings. Prolapse of the mitral leaflets may be secondary to papillary muscle dysfunction (as in coronary disease), congenital heart disease, hypertrophic cardiomyopathy, or chronic rheumatic mitral disease.[9] It is often a primary condition which ". . . appears to be a degenerative condition of leaflets and chordae, associated on histopathology with increased myxomatous tissue, with resultant lengthening and alteration of chordae, and somewhat voluminous leaflets."[9] Abnormal histochemical findings have also been reported on endocardial biopsy of the right ventricle.[10]

The syndrome should be searched for in young patients, especially women, who have symptoms of palpitations, chest pain, and anxiety attacks. Disorders in the regulation of autonomic functions have been proposed to explain some of the symptomatology.[11] Abnormalities in platelet function may play a role in the development of transient ischemic attacks or strokes.[12] In one series of 60 patients with stroke prior to age 45, 40% had underlying mitral valve prolapse.[13]

Given the prevalence of the syndrome, the prognosis is excellent. Only one of my 100 patients died suddenly, and he had chronic high-grade ventricular ectopy that had been unresponsive to a variety of antiarrhythmic agents. Risk factors for sudden death, in addition to complex ventricular ectopy in the face of progressive mitral regurgitation, include ST-T abnormalities on the resting ECG, a history of syncope, and a family history of unexplained, sudden death.[14]

Summary

The MVP syndrome was noted in 10% of 100 apparently healthy employees and spouses.

Analysis of 100 cases of MVP seen by the author in a private cardiology practice showed that 49% had palpitations and/or chest pain. Thirty-four percent were asymptomatic. A midsystolic click was heard in 64%, a click-murmur in 31%, and a late systolic murmur in 5%. The resting ECG was abnormal in 18%. The exercise ECG, although normal in 70%, occasionally revealed exercise-related arrhythmias. At least one of the five cases with ST-segment depression was shown to be false positive after coronary angiography.

Five brief case histories illustrate the many clinical faces of this syndrome. Sudden death, which occurred in one of these 100 cases, is rare, and the overall prognosis is excellent.

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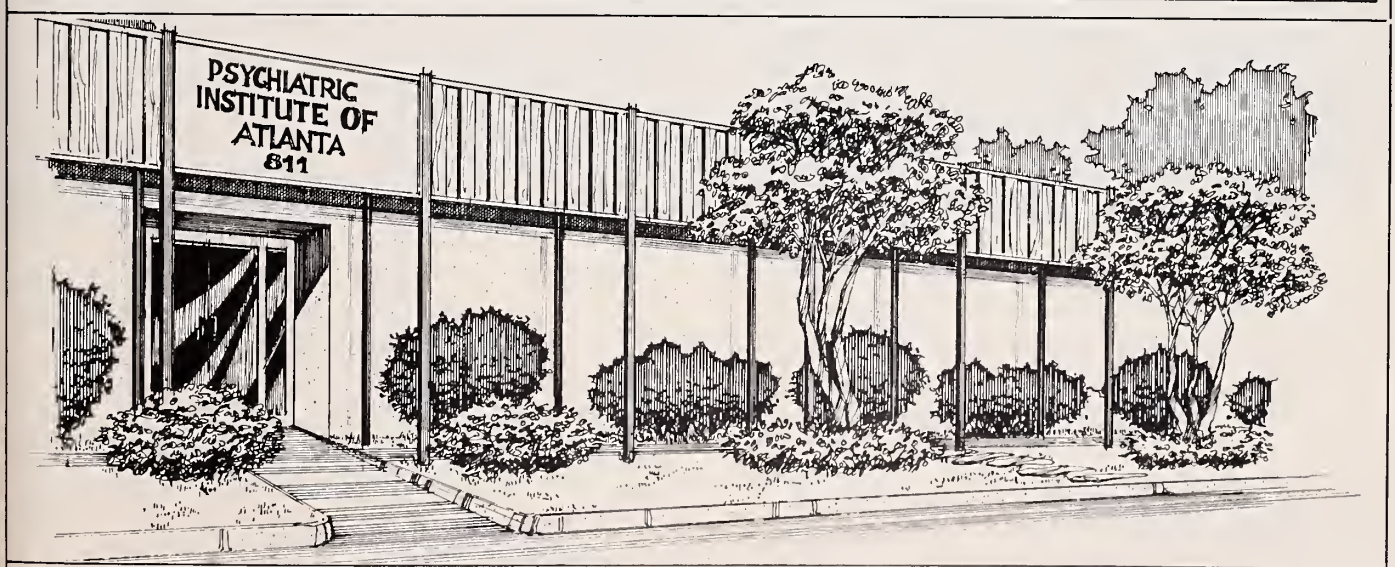
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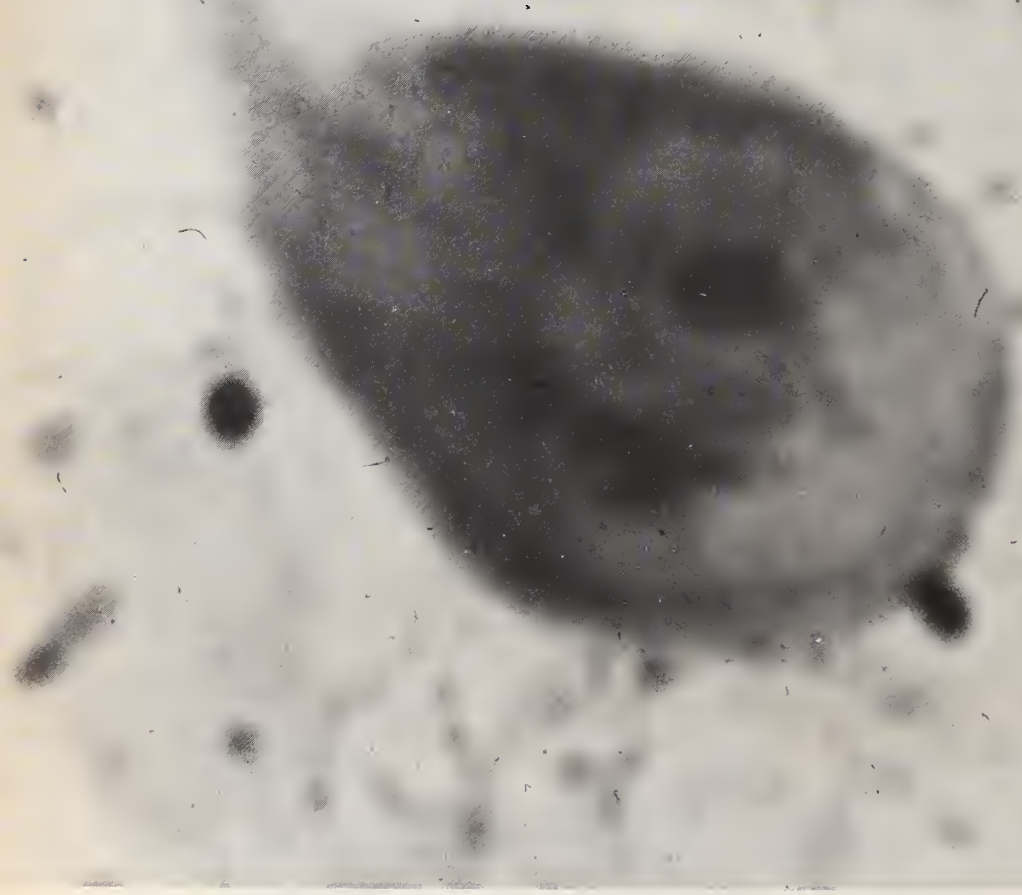


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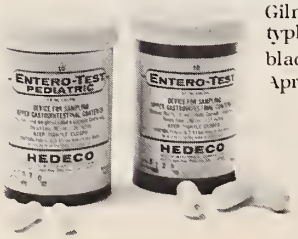
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The purpose of this paper is to emphasize how easily the clinician can misdiagnose phlebitis.

The Diagnosis of Phlebitis — Role of the Doppler and Plethysmograph

F. LEVERING NEELY, M.D., *Atlanta**

Introduction

It is generally agreed in most textbooks of medicine and in many articles that the clinical diagnosis of thrombophlebitis is not accurate.[1] Most authors state that if one uses signs and symptoms only, one will correctly diagnose only about 50% of the cases.[2] This figure is in contrast to the x-ray venogram which is considered to be almost 100% accurate and is thus the ultimate in correct diagnosis.

The venogram is an invasive procedure which can be painful and can cause reactions, even phlebitis itself. Thus, the clinician prefers not to use a venogram unless the diagnosis is in serious question or if it seems crucial to know the correct diagnosis before beginning a long course of treatment. Anticoagulants may have serious or dangerous side effects.

It is only natural that non-invasive procedures should have gained in popularity. These methods include the use of the Doppler for checking venous flow,[3, 4] the plethysmogram[5] which measures venous run off by the pulse volume recorder, and the nuclear scanning technique which uses radioactive fibrinogen. Each of these methods has its advocates. Various claims have been made for each as to its accuracy[6] and specificity.

Several authors recommend two non-invasive methods on suspected cases of thrombophlebitis.[4, 7, 8] The first is the use of the Doppler for detecting blood flow in the femoral vein, the popliteal vein, and the posterior tibial vein. The second is the pulse volume plethysmograph[9] for measuring the speed of the run off in the femoral vein. The first is most helpful in calf vein thrombosis and the second in femoral and iliac vein thrombosis. Other authors have found a 95% accuracy by using these combined methods when comparing with venograms. Our general experience confirms this figure.[3-5]

The most surprising fact that has emerged from our studies is that there are many patients with a clinical diagnosis of thrombophlebitis who are found to have no evidence of thrombophlebitis by noninvasive methods. These are in patients who seem to have typical thrombophlebitis with unilateral or bilateral swelling and local tenderness. Previous authors have stressed how often the clinician fails to find phlebitis by clinical means. These are errors in underdiagnosis. The purpose of this paper is to emphasize how easily the clinician can misdiagnose phlebitis. An analysis of these misdiagnosed cases will be made. Most of the patients in this group ultimately were found to have another condition. Thus, the Doppler and plethysmograph are crucial in the proper treatment of any suspected cases of thrombophlebitis. The decision for treatment with anticoagulants will thus depend on these noninvasive methods. The clinician must be aware of these various conditions, as their treatment may be entirely different from that of true thrombophlebitis.

Methods

The Vascular Laboratory at Piedmont Hospital in Atlanta uses a Medsonic Doppler uni-directional flow meter over the veins in the leg with earphones to detect normal flow, lack of flow, reduced flow, augmentation, and reversal of flow. The scoring system developed at the Massachusetts General Hospital to diagnose calf phlebitis is followed. The pulse

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volume recorder is the unit manufactured by Life Science Company. This method is used to diagnose thrombophlebitis in the femoral and popliteal veins. Cuffs are placed around the thigh and calf. The upper cuff is inflated to 60 mm. of mercury. The lower cuff records the volume in the calf. The upper cuff is suddenly released, and the lower cuff records the speed of run off in the calf veins.

Case Reports

All cases with clinical signs and symptoms of thrombophlebitis but with negative non-invasive tests were collected and analyzed. A brief description of some of these cases follows.

Patient #1 — The first patient was one with a large, swollen, tender vein quite visible under the skin of the calf. Non-invasive tests were negative and showed good venous run off. This was obviously a case of superficial phlebitis. The value of the tests was that they helped determine the treatment. Anticoagulants were used. The patient was ambulated more quickly, as there is a slight danger of pulmonary infarct from superficial phlebitis.

A variety of other disease conditions, such as incompetent veins with unilateral swelling, lymphedema with good venous run off, leukemic infiltrate, erythema nodosum, and hemarthrosis, often resemble thrombophlebitis.

Patient #2 — The second patient had sudden onset of pain in the upper calf. There was local swelling and marked tenderness. Non-invasive studies were negative for thrombophlebitis. Anticoagulants were withheld. Within 3 days, bluish discoloration and more localized swelling developed, and a diagnosis of hematoma of the calf was made. Anticoagulants would have made this condition worse.

Patient #3 — The third patient was one with chronic congestive heart failure who experienced massive edema of both entire legs. The calves were tender, suggesting thrombophlebitis. Doppler and venous run-off tests were normal. Diuretic treatment rapidly abated the symptoms. These tests for thrombophlebitis saved the patient from anticoagulant treatment.

Patient #4 — The fourth patient had bilateral edema which was much more marked on the left side, suggesting phlebitis. Again, the vascular studies were normal. Following improvement in renal status, his symptoms subsided. The negative tests avoided the use of anticoagulants.

Patient #5 — The fifth patient was obese and had documented phlebitis with positive non-invasive tests and a positive venogram 1 year previously. She was on long-term anticoagulants. She had onset of severe pain in one calf with marked tenderness. Plethysmograph and Doppler studies were repeatedly negative. Several more similar episodes occurred. The diagnosis of small ruptured veins of the calf was considered. Another possibility was adiposo dolorosa. No definite diagnosis was made, but the venous studies prevented hospitalization of this patient several times.

Other conditions observed which closely resemble thrombophlebitis were: 1) incompetent veins with unilateral swelling, 2) lymphedema with good venous run off, 3) strained muscle with possible small hemorrhages in the muscle, 4) leukemic infiltrate, 5) erythema nodosum, 6) hemarthrosis, 7) Baker's cyst, 8) post-phlebetic stasis, 9) varicose veins, 10) leg trauma, 11) cellulitis, 12) lymphangitis, 13) arthritis, and 14) myositis (polymyalgia rheumatica).

Conclusions

The Doppler and venous run-off studies can be a great help to the clinician not only to diagnose phlebitis when symptoms are minimal but also to exclude the diagnosis when symptoms are highly suggestive of thrombophlebitis. Thus, these non-invasive studies can help prevent short or long-term anticoagulant treatment. The tests also can preclude unnecessary hospitalization. It behooves all good clinicians to make use of these valuable adjuncts in diagnosis. The clinician should also be aware of the clinical states that closely mimic thrombophlebitis, as these conditions often demand an entirely different treatment.

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Two fatal cases are reviewed, with the admonition that thrombocytopenia is reason enough for stopping heparin treatment and using instead other types of anticoagulants.

Thrombocytopenia and Thrombosis Associated With Heparin Therapy

ROBERT B. COPELAND, M.D., *LaGrange**

Abstract

Two patients with thrombocytopenia and fatal complications of arterial thrombosis associated with heparin therapy are reviewed. Both patients had been on heparin continuously for more than 1 week. Initially, their platelets appeared to be normal, but severe thrombocytopenia was present in both at the time unanticipated arterial thrombosis appeared. Despite stopping heparin and surgical management of the major arterial thrombosis, both patients died.

Recent studies have shown that heparin administration can be associated with complement-mediated platelet injury. This and possibly other immune or nonimmune reactions may be the mechanism of thrombocytopenia and thrombosis associated with heparin therapy.

THROMBOCYTOPENIA may occur in as many as one third of patients treated with heparin.[1, 2] When it occurs, it is usually apparent by the third day and essentially always by the seventh day of treatment. For most patients, the thrombocytopenia does not appear to be of any clinical significance but in a small number of patients, there are associated hemorrhagic problems.[3, 4] In an even smaller number of patients, there are thrombotic problems which may be fatal.[5, 6]

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Report of Two Cases

Case #1:

A 75-year-old man was admitted to the hospital with symptomatic prostatism. Admission CBC was within normal limits and platelets were noted to be normal on smear. His previous general health had been excellent. There was no history of allergic problems. A suprapubic prostatectomy was done without apparent problems.

Twelve days post-operatively, the patient was noted to have a swollen and tender left calf. He was started on heparin by continuous intravenous (IV) drip. Initially, his leg appeared to improve. On the eighth day after heparin was started, he had acute occlusion of the left femoral artery. A femoral thrombectomy was done. On the day of surgery, the patient's platelets were 27,000. His hematocrit was 29 and hemoglobin 10. No schistocytes were present on blood smear. Repeat platelet count was 32,000.

Heparin was stopped and Warfarin was subsequently used for anticoagulation. No other changes in his medications were made. Repeat platelet counts revealed progressive increase to normal over the next 5 days.

After the vascular surgery, the patient did not have adequate return of circulation in his lower leg. On the sixth post-operative day, the lower leg was amputated. His subsequent course was complicated by repeated episodes of abrupt dyspnea and hypotension. Sepsis developed at the amputation site, and the patient died.

Case #2:

A 55-year-old man was admitted to the hospital

because of chest pain which was severe and related to exertion. It was atypical for angina in that it was usually located in his right axilla. He also had problems with headaches and chronic sinus symptoms.

Admission physical examination revealed no abnormal cardiac findings. Peripheral arterial pulses were normal. He had no palpable lymphadenopathy or hepatosplenomegaly. His electrocardiogram had nonspecific ST and T wave abnormalities. CBC revealed white blood cell count of 10,000, and platelets were described as adequate on peripheral smear.

The patient's pain was difficult to control. It persisted despite nitrates and propranolol. Continuous IV heparin and later IV glucose-insulin and potassium were used. Abnormalities of cardiac enzymes or diagnostic ECG changes did not develop. On the eighth hospital day, the seventh after initiation of heparin therapy, acute pain appeared in the right lower extremity. He was noted to have no right femoral pulse. A right femoral embolectomy was performed, and a large thrombus was removed. Thrombotic material was also removed from his left femoral artery at that time. The next day the patient had a transient hypotensive episode. His ECG developed features of an acute inferior and probable true posterior infarction. He was noted to have ecchymoses and some bleeding from surgical and venapuncture sites. His platelet count was 20,000, with fibrinogen 120, PTT 36/28, and FSP greater than 40. No schistocytes were present on smear.

The patient experienced recurrent severe pains in his legs and subsequently had a repeat left femoral embolectomy. The next day he complained of right arm pains, became hypotensive, and died.

Autopsy revealed an extensive mural thrombus in the abdominal aorta and a recent thromboembolus in the pulmonary artery. Arteriosclerosis of the aorta and systemic arteries was not severe. There were thrombi in the left anterior descending coronary artery and the left circumflex coronary artery and recent infarction of the posterolateral wall of the left ventricle superimposed on multiple older microinfarcts. He had severe three vessel coronary arteriosclerosis but no apparent occlusion of the right coronary artery.

Discussion

The mechanisms of thrombocytopenia that are associated with heparin therapy are not fully established. In a recent study, patients who became thrombocytopenic while receiving heparin were shown to have increased levels of IgG and C_3.[7] Their plasma caused the release of serotonin from normal platelets with concentration of heparin within the usual therapeutic range. This reaction required IgG and an intact classic complement pathway. Plasma from some heparin-treated patients who were not thrombocytopenic was shown to cause the release of serotonin when heparin was added in greater concentration than the usual therapeutic range. That reaction also required IgG and complement. Those studies indicate that heparin administration can be associated with complement-mediated platelet injury and may to some extent be dose dependent. Other immune and nonimmune mechanisms may also be important in the pathogenesis of heparin-associated thrombocytopenia and thrombosis.

Patients receiving heparin therapy, either low dose or standard dose, by whatever route, should have platelet counts on the third and seventh days of therapy. The appearance of thrombocytopenia is reason enough for stopping heparin treatment and using instead other types of anticoagulants. Platelet transfusion should not be used in heparin-associated thrombocytopenia, as it may transiently increase the potential problem with thrombosis.[4, 6]

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Each Tablet Contains:

Pentylenetetrazol	25.0 mg
Pheniramine maleate	12.5 mg
Nicotinic acid	50.0 mg

Clinically proven actions

- Antihistaminic
- Cerebral stimulant
- Vasodilator

Few side effects

- Vasodilation occasionally causes facial flushing which can be minimized by recommending that Ru-Vert® be taken following meals or with food.

Dosage

- One or two tablets three times a day

Please see next page for a summary of prescribing information

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See following prescribing information.

DESCRIPTION: Each tablet contains the following active ingredients:

Pentylenetetrazol	25.0 mg
Pheniramine maleate	12.5 mg
Nicotinic acid	50.0 mg

INDICATIONS: Ru-Vert is indicated as an adjunct therapy in the symptomatic treatment of acute or chronic vertigo.

CONTRAINDICATIONS: Convulsive disorders or known history of sensitivity to any of the listed active ingredients. Because of the vasodilating action of nicotinic acid, Ru-Vert should not be used in patients with hypotension.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with Ru-Vert.

OVERDOSAGE: Signs and symptoms of acute overdose may be due primarily from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION: The recommended dosage of Ru-Vert for vertigo or motion sickness is 1 or 2 tablets three times a day with meals or light snacks.

This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

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Bottles of 300 tablets	NDC 0524-0060-03

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Pediatricians should be aware of this association and its natural course to avoid unnecessary invasive diagnostic procedures in newborns.

ABO Hemolytic Disease of the Newborn Associated with Direct Reacting Hyperbilirubinemia

ZEBA NAJAK, M.B.Ch.B., WILLIAM P. KANTO, JR., M.D., *Atlanta,* and PETER J. CARRILLO, M.D., *Athens**

Abstract

We report on six patients with neonatal conjugated hyperbilirubinemia in whom the only identifiable etiology was ABO hemolytic disease. In one patient who had a liver biopsy, the changes were nonspecific. In all six, the liver dysfunction resolved in 4 to 6 weeks with no particular treatment. These cases illustrate the need to consider ABO hemolytic disease as the cause for early, rapidly rising, direct reacting bilirubin in neonates.

In neonates, an elevated, direct reacting fraction of the total bilirubin concentration is generally considered more ominous than the usual increased concentration of indirect bilirubin. It has been recommended that any elevation of the direct fraction suggests an underlying pathologic process and that prompt evaluation should be undertaken to identify the cause of the alteration.[1] The differential diagnosis should include infection (viral, bacterial, and spirochetal), intra and extra hepatic biliary atresia, inborn errors of metabolism that predispose to liver damage, exposure to hepatotoxic drugs or chemicals, and the rarely mentioned hemolytic disease of the newborn.[2] The incidence of obstructive jaundice in hemolytic disease of the newborn has been reported to be between 8 and 10%.[3] Although most cases of elevation of the direct fraction have been described with Rh incompatibility, there is one report of this in association with ABO incompatibility.[4]

We are reporting here on six newborns with severe ABO hemolytic disease in whom the elevation of the direct fraction exceeded the increase in indirect fraction of bilirubin (Figure 1). Clinicians should be aware of this association and its natural course so that they include ABO hemolytic disease in the differential diagnosis of early (within 24 hours of birth) marked elevations of direct bilirubin.

Tables 1 and 2 summarize pertinent features, including laboratory data of these six cases. These first came to our attention because of Case 2; when we inquired into her family history, we discovered that the older sibling (Case 1) had had a similar course of hyperbilirubinemia. This is of interest since ABO hemolytic disease has been known to recur in subsequent pregnancies.[5] The other four cases were recognized in the next few months after we became aware of this relationship.

Case 1 is a sibling of this child and had a similar history and presentation. In this patient, a liver biopsy was performed because of the persistent direct fraction of bilirubin at 2 weeks. This histopathology revealed nonspecific liver damage with intracanalicular and intracellular bile stasis, giant cells, and mild to moderate diffuse fibrosis. At 3¼ months of age, she was thriving and non-icteric. The details of

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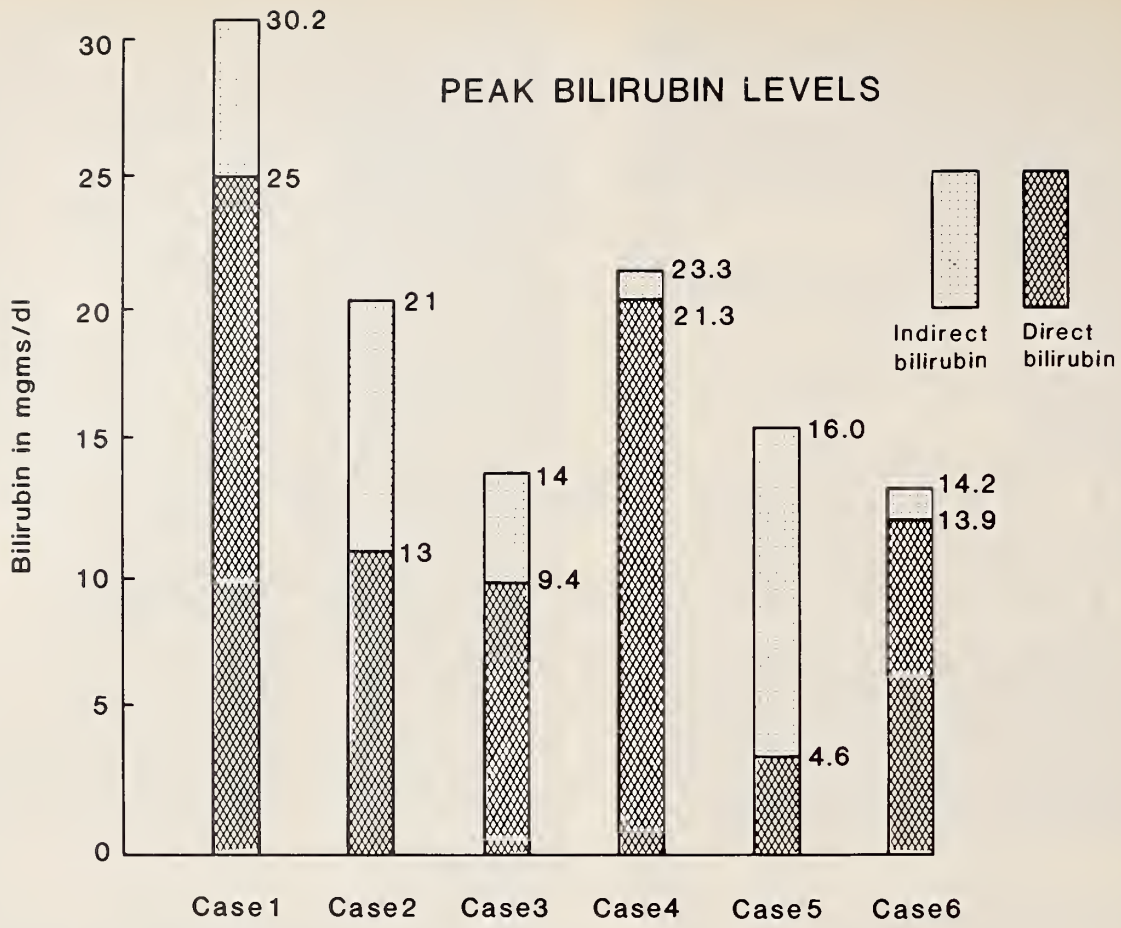


Figure 1 — Each bar represents the peak bilirubin for an individual case and shows the proportion of this bilirubin that is the direct or indirect reacting fraction.

her course are shown in Tables 1 and 2, and Figures 2 and 3 show her bilirubin course.

In the six patients studied here, visible jaundice and laboratory evidence of a brisk hemolytic process developed within the first 24 hours (Tables 1 and 2). Two of the infants had blood type A+, and four had blood type B+. All of the mothers were blood type O+. The initial bilirubins, all of which were obtained on the first day of life, showed elevations of the bilirubin concentration and were remarkable in

TABLE 1 — Perinatal Characteristics of Newborns with Direct Reacting Hyperbilirubinemia

Case	Maternal Blood Type	Maternal VDRL	Drugs/Pregnancy Complications & Delivery	Baby's Blood Type	Gest. Age (weeks)	Birth Weight (kg)	Apgar 1min.	Apgar 5min.	Direct Coombs	Age of Initial Bilirubin	Initial Bilirubin Total/Direct mg/dl
1	0+	NR	None Vaginal	B+	40	2.85	9	9	+ Anti-B	3 hrs.	20.3/14.4
2	0+	NR	None Vaginal	B+	40	3.0	5	9	+ Anti-B	6 hrs.	14.9/8.4
3	0+	NR	None C-section Meconium	A+	37	2.6	2	7	+ Anti-A	6 hrs.	12/5.8
4	0+	NR	Diabetic NPH Insulin 10 u/day Vaginal	B+	40	3.0	-	9	+ Anti-B	19 hrs.	13.4/9.6
5	0+	NR	Antepartum Hemorrhage Vaginal Meconium	B+	41	3.0	1	7	+	4 hrs.	12/3.4
6	0+	NR	Hypertension Aldomet Vaginal Meconium	A+	38	3.1	1	3	+ Anti-A	17 hrs.	11/3.8

* NR = Non reactive.

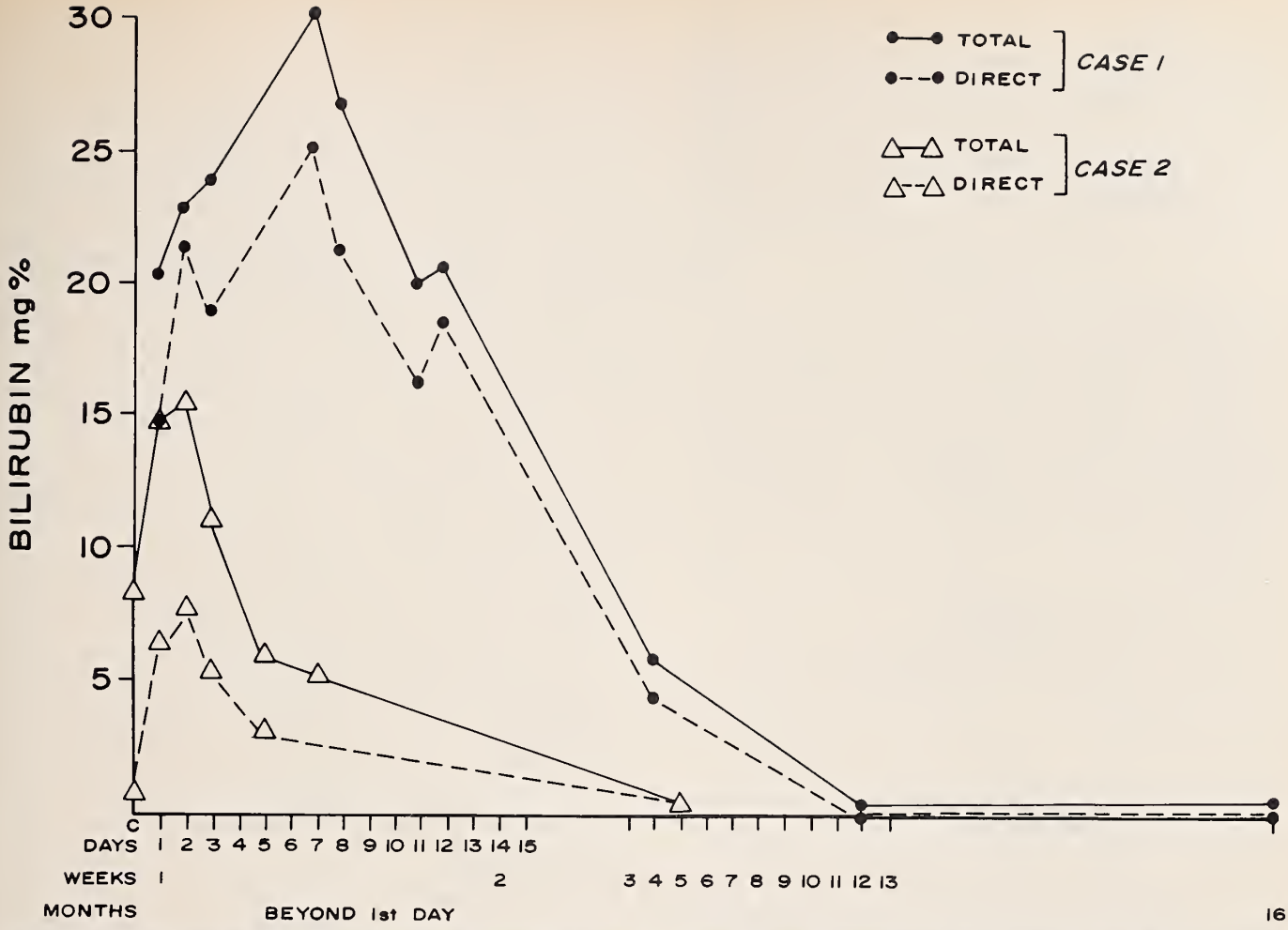


Figure 2 — The course of bilirubin over the initial 24 hours in Cases 1 and 2, illustrating the elevation of direct fraction of bilirubin parallel to the total bilirubin concentration.

that the direct fractions were also elevated (range 3.4-14.4 mg/dl). The elevation of the direct bilirubins continued to increase during the next 1-2 days and in five of the six infants, when the peak total bilirubin concentrations were recorded, the direct fractions were 50% or greater of the total (Figure 3).

The direct hyperbilirubinemia then began to slowly decline but was still present for a range of 4-12 weeks. Laboratory evaluation of the infants demonstrated only the ABO hemolytic disease and biochemical evidence of nonspecific hepatocellular damage. A liver biopsy from Case 2 was nonspecific, indicative only of generalized hepatocellular damage.

All six patients were followed until there was no evidence of residual liver dysfunction, growth, or functional impairment (Table 2).

Discussion

Hemolytic disease of the newborn associated with

TABLE 2 — Laboratory Data, Treatment, and Outcome of Newborns with Direct Reacting Hyperbilirubinemia

Case	Initial Hct. %	Retics %	WBC/mm³	Bands %	Segs %	SGOT units/ut	Treatment	Age when last seen	Total Bilirubin mg/dl at last visit
1	20	27.6	14,200	13	37	300 (Day 1)	Phototherapy Exchange transfusion Cholestyramine	16 months	0.2
2	43.8	69	45,000	36	36	432 (Day 1)	Exchange transfusion Phototherapy	5½ weeks	0.2
3	35.7	25	27,900	10	20	275 (Day 1)	Phototherapy	11 months	1.0
4	39	23.3	20,900	20	46	196 (Day 1)	Phototherapy	1 year	0.2
5	34.8	19.4	25,800	14	20	32 (Day 4)	Phototherapy	22 months	0.6
6	40.3	—	25,000	20	40	37 (Day 9)	Phototherapy	15 months	3.8 (@ 1 Month)

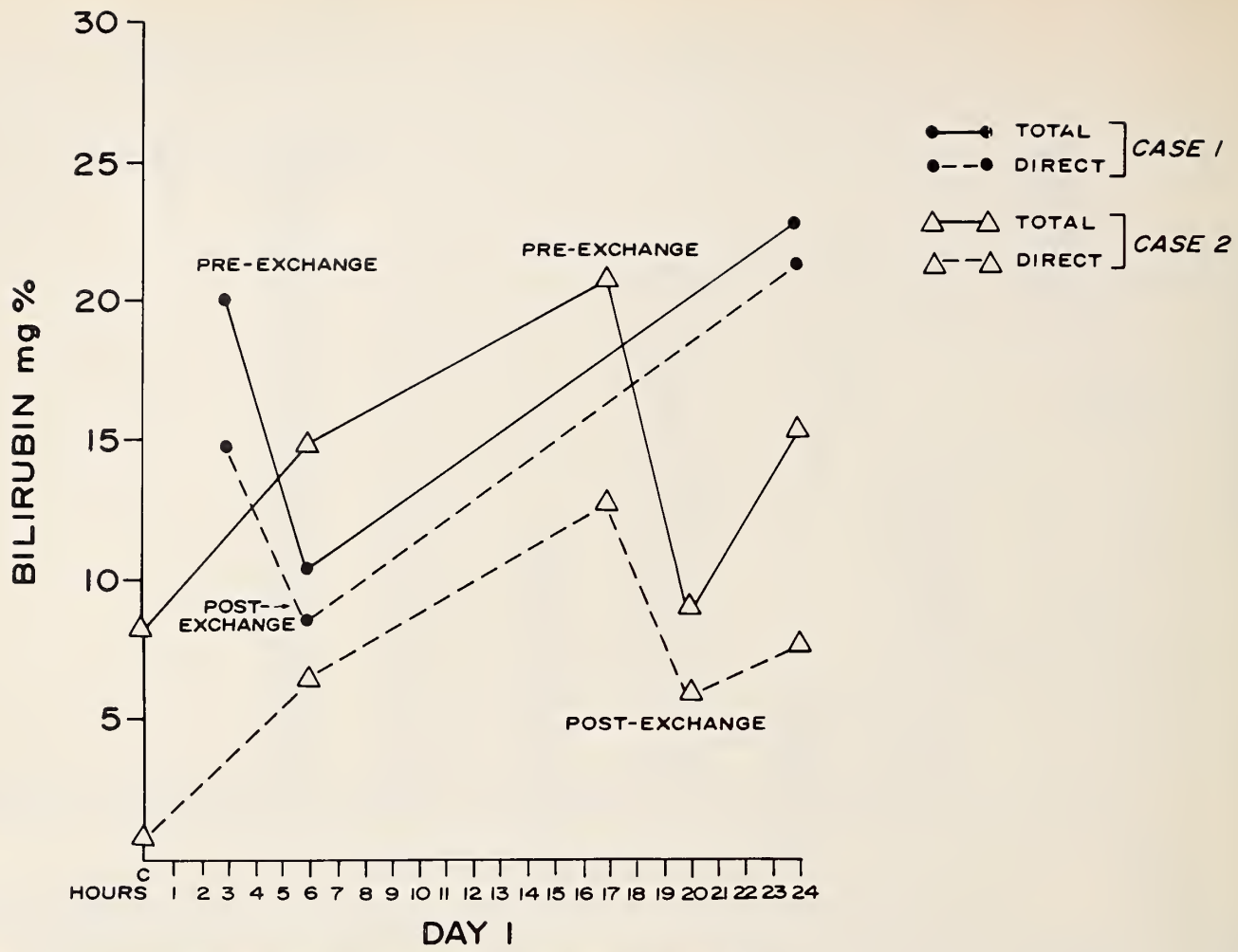


Figure 3 — The overall bilirubin course in Cases 1 and 2 and at follow up.

direct hyperbilirubinemia is only briefly mentioned in standard textbooks of neonatology.[7, 8] It is less frequently mentioned in association with hepatocellular damage. However, earlier studies by Dunn,[3] Craig,[9] and Cornblath[10] support these associations. These studies describe patients with Rh hemolytic disease whose bilirubin elevations consisted mostly of the direct fraction. However, only the work by Harris[4] makes a brief mention of a case related to ABO hemolytic disease. Liver histopathology described in these patients with Rh isoimmunization is very similar to that found in our first case, i.e., varying degrees of intracanalicular bile stasis, giant cell formation, hepatocellular degeneration, and fibrosis. These findings are nonspecific indicators of hepatocellular damage and do not incriminate a particular etiology.

In the six patients we studied, there appeared to be no abnormality present other than ABO hemolytic disease which could account for the marked elevation in both total and direct bilirubin. Therefore, we believe that the ABO hemolytic process was causally related to the abnormal biochemical findings.

It has previously been suggested that the elevation of the direct bilirubin is a function of the liver being capable of conjugating bilirubin but being unable to excrete the tremendous bilirubin load presented to it.[11] An alternative explanation is that the newborn liver, which is the site of fetal erythropoesis in hemolytic disease, receives blood rich with maternal antibody from the placenta. The A-like and B-like antigens in the liver react to this maternal antibody, producing cellular changes.[3, 12] The cells may swell, producing bile canalicular obstruction, and/or the cellular change may reduce their secretory ability. With time or following exchange transfusion when the antibody levels decrease, hepatic cell function resumes.

Case Reports

Case 2 was the full-term product of a 22-year-old, O positive, VDRL negative woman who had one other living child (Case 1). Her pregnancy was uncomplicated, and she took no drugs except for vitamins and iron. Her membranes ruptured 1½ hours prior to delivery. Meperidine was given 1 hour prior to delivery. During labor, some mild fetal heart rate type II decelerations were noted by fetal monitoring. At delivery, the cord was around the neck once. The Apgar scores at one and five minutes were 5 and 9. Naloxone® and oxygen were given with good response. On admission to the nursery, the infant was

noted to be mildly lethargic and jaundiced. Physical examination revealed a 3 kg baby, whose liver was palpable 2.5 cm below the right costal margin and whose spleen was not palpable. Other findings were within normal limits. Laboratory data revealed hematocrit 43.8%, retic count 69%, blood sugar 16 mg/dl. The cord bilirubin was 8.3 mg/dl total and 0.8 mg/dl direct, WBC was 45,000/mm^3. Platelet count was 101/mm^3 and SGOT 432 U/L (normal 10-40 U/L). Blood type was B positive, Coombs (direct and type specific for anti-B) was positive. In view of the markedly elevated WBC, blood, urine, and cerebrospinal specimens were obtained and TORCH[6] studies initiated. The infant was given ampicillin and gentamycin until the above specimens were culture negative. TORCH screen was also unrevealing. The bilirubin rose rapidly and at 6 hours of age, the total was 14.9 mg/dl and the direct was 8.4 mg/dl. Because of evidence suggesting severe hemolysis, a double volume exchange transfusion was done at 17 hours of age when the total bilirubin was 21 mg/dl and direct 13 mg/dl. Evaluation of this, as in the previous sibling, was negative, with the exception of ABO hemolytic disease. Figure 2 describes the course of bilirubin values over the first 24 hours. The child was discharged at 7 days of age in good condition. Figure 3 describes the overall bilirubin course.

Follow-up examination at 5½ weeks revealed a normally thriving infant. There was no jaundice; however, the liver was still 2.5 cm below the costal margin. Laboratory data at this time showed a hematocrit 30%, retic count 2.3, SGOT 46 U/L, albumin 4.1 mg/dl, and bilirubin 0.2 mg/dl total.

It is interesting to note that in four of the five cases, an increased ratio of bands to segmented neutrophils was present. Despite attempts to identify an infectious agent, none was isolated, and the ratio gradually returned to normal. We suggest this is merely a nonspecific response of hematopoietic tissues being stimulated by the marked hemolysis.[13]

Summary

All six patients had early elevation (within 24 hours, Figure 2) in the direct reacting bilirubin and a marked, sustained decline by 30 days of age. At 3 months of age, liver function returned to normal and remained normal thereafter. Practicing pediatricians should be aware of this association and its natural course to avoid unnecessary invasive diagnostic procedures in newborns.

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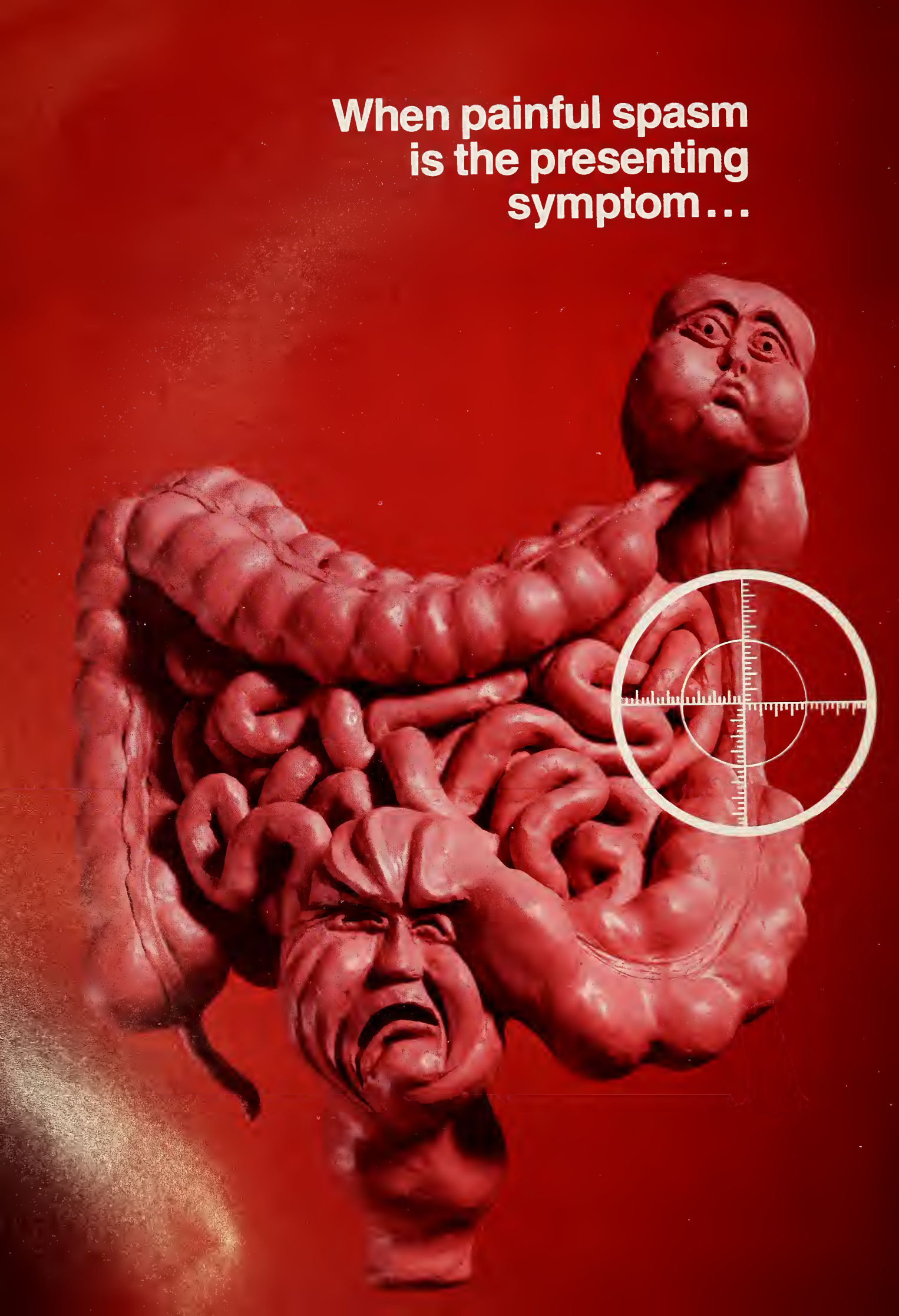
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(References for Cancer Page, pp. 289-292)

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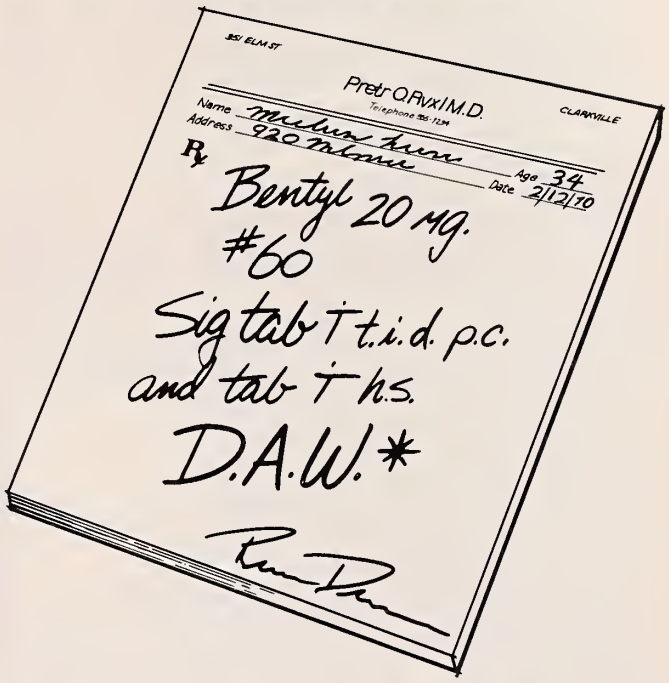
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*This drug has been classified "probably" effective for this indication.

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Reference:
1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

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CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

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There is a tremendous bilateral gain and reward to both the student and the impaired physician.

The Role of the Medical Student in the Treatment of Impaired Physicians

G. DOUGLAS TALBOTT, M.D., F.A.C.P., *Smyrna**

SINCE THE INCEPTION of the Medical Association of Georgia's Disabled Doctors Program, more than 400 physicians have been involved in this program. As restoration of the impaired physician's self-dignity is a critical therapeutic element in his/her recovery, medical students in medical schools in Georgia, particularly Emory, have been found to be an invaluable asset. The philosophy of using medical students to interact with the recovering impaired physicians has been based upon bilateral benefits. For the impaired physician, it offers a powerful stimulus for him/her to regain his/her professional dignity; for the medical students there is not only interest and concern but also a real lesson in their identification with the impaired physicians leading to prophylactic attitudes and practices.

Experientially in the Georgia's Disabled Doctors Program, there are three ways the students are involved. First, weekly clinical rounds at the treatment centers are held. Second, seminars with groups of impaired physicians meet with the students in their own medical schools telling their stories of addictive disease within the context of "It Couldn't Have Happened to Me as a Junior Medical Student." Third, every 3 months, groups of medical students and their significant others meet with graduates and their wives. These meetings are entitled, "Things I Wish They Had Taught Me in Medical School." The details of these three medical student-impaired physicians programs involving medical students and impaired physicians are described in this paper.

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The Role of Medical Students

Weekly, a group of students from the junior class of the Emory University School of Medicine have been coming to rounds at two of the initial treatment centers for impaired physicians. There the students have an opportunity to meet with these physicians and interview them. The doctors in turn do some teaching, using themselves as examples. This intensive one-to-one dialogue between the student and the disabled doctor offers the latter the feeling of being the teacher, mentor and/or instructor. He/she has an audience who is willing to non-judgmentally and non-punitively listen to his or her story. The student on the other hand sees himself or herself a time ago when this sick physician was a junior student as themselves. Following these one-to-one interviews, many times I have heard students say, "There but for the grace of God go I."

From the beginning of treatment in the Georgia's Disabled Doctors Program, the impaired physician is schooled, lectured, and educated in the disease precept of chemical dependency. He/she is taught that this is a disease and consequently this allows for sorrow, pain, and remorse. However, their schooling teaches them the biochemical-genetic aspects of this disease and that this disease more closely resembles diabetes than any other modern disease. Therefore, there is no room for embarrassment and shame any more than there is in the diabetes or heart failure from sodium ingestion. Experientially, we have found that the best way for our impaired physicians to overcome the shame, embarrassment, and guilt that they feel nevertheless is to participate in the junior class medical seminars entitled, "It Couldn't

Have Happened to Me When I Was a Junior in Medical School.'' In groups of five to seven, the impaired physicians meet with the junior students, and each disabled doctor gives a 5-10 minute talk about the evolution and development of their disease. These talks are centered around the theme that it couldn't have happened to them when they were junior medical students. As ages, sex, and medical specialities vary widely in the now constant 40 disabled doctors who are in treatment, identification is very strong with the students. This is particularly true when the disabled physician is a medical student, intern, resident, or young practicing physician in his/her twenties and thirties. However, the emotional impact has also been valuable with the chairmen of departments in medical schools, Nobel laureate physicians, and nationally known disabled doctors, as well as those who are highly successful and widely acclaimed physicians of the community. Again, almost invariably the impaired physician who talks of his or her disease talks of the mental and emotional catharsis that follows the relating of their story to the students. Ample time is left in these sessions for informal dialogue with the student audience. These dialogues have been both constructive and revealing as it is obvious that we are witnessing the new generation of physicians meeting the old generation, a different breed of physicians raised in a different chemical culture than the past medical generation.

Six years ago in the Georgia Disabled Doctors Program, a study was initiated based on the premise that no physician would have become chemically impaired if he or she had not abused abnormal mood altering drugs. Therefore, in over 100 physicians, a questionnaire followed by intensive personal interviews assessed the situation, emotions, events, or incidents that led to this chemical abuse. As this list expanded, grew, was culled, and assessed, the impaired physicians began to refer to the list as, ''Things I Wish They Had Taught Me in Medical School.'' Consequently, sessions began, where on a mid-week evening, junior medical students brought their significant others to meet with four or five graduates of the Disabled Doctors Program who were accompanied by their wives. Item by item as evidenced by the list below, each topic is discussed individually.

Things I Wish They Had Taught Me in Medical School Medical Student Questions

1. Help with the dying patient and grief.
2. The patient to whom the physician is sexually and emotionally attracted.
3. True empathy rather than aloofness or over-identification.
4. How to pick a family doctor.
5. Overwork — its significance and avoidance.
6. What is a reasonable income.
7. Leisure time and hobbies for the doctor.
8. When, where, and why vacations for a physician.
9. How to be a doctor/father, doctor/spouse, doctor/mother — the difference from laypeople.
10. When a patient leaves me for another doctor.
11. When I don't like a patient — yet he/she is my patient.
12. I am not helping the patient — when do I let go.
13. How much spirituality, how much religion, do I use with my patient.
14. The significance and dangers of treating ourselves.
15. What is drug abuse as applied to me — what is the danger.
16. How to treat a doctor, the doctor's spouse, the children.
17. How should I plan for my old age, my retirement.
18. What is an ideal social life for a doctor.
19. How do I say I don't know as a physician, an expert.
20. How do I select my specialty.
21. How do I select a partner.
22. Should I stay in a medical school environment, in academia, or go out in practice.
23. How can I decide to be a machine doctor (x-ray, pathologist) or a people doctor.
24. How do I prepare myself for court appearances, legal involvement.
25. How much charity work is my obligation.
26. Do I want to practice alone, partnership, group, in a clinic.
27. Do I want to practice in private, county, state, or federal medicine.
28. What is a good time to get married.
29. How do I learn to say no.
30. How do you leave your work at the office.
31. How do I get over ''being trained so I do not share my feelings.''

Again, it became so apparent that there is a tremendous bilateral gain and reward to both the student and the impaired physician. New insights, new attitudes, and new understandings became a reality in both groups and between both groups. It has been equally valuable to have the wives and often intended wives of the medical students present. There is indeed a difference between being a wife and a doctor's wife as there is the same difference between being a mother and a doctor/mother. This aspect has been of particular interest to the Auxiliary of the Medical Association of Georgia.

Because of the newness of the Disabled Doctors Program, with hard data available for only 5 years, and because of a lack of personnel and funding for sophisticated data gathering, observations are still experiential and anecdotal in terms of absolute results of these seminars and sessions. However, there appears to be an indisputable pattern of prophylactic value to the students as evidenced in interviews 5 years later with a substantial number of the junior students in the first class. Equally, there appears to be tremendous therapeutic value to the disabled doctors in restoration of professional dignity. As such, it is envisaged that this may in part serve as a model for medical student interrelationships with disabled doctors programs in other states and with other medical schools.

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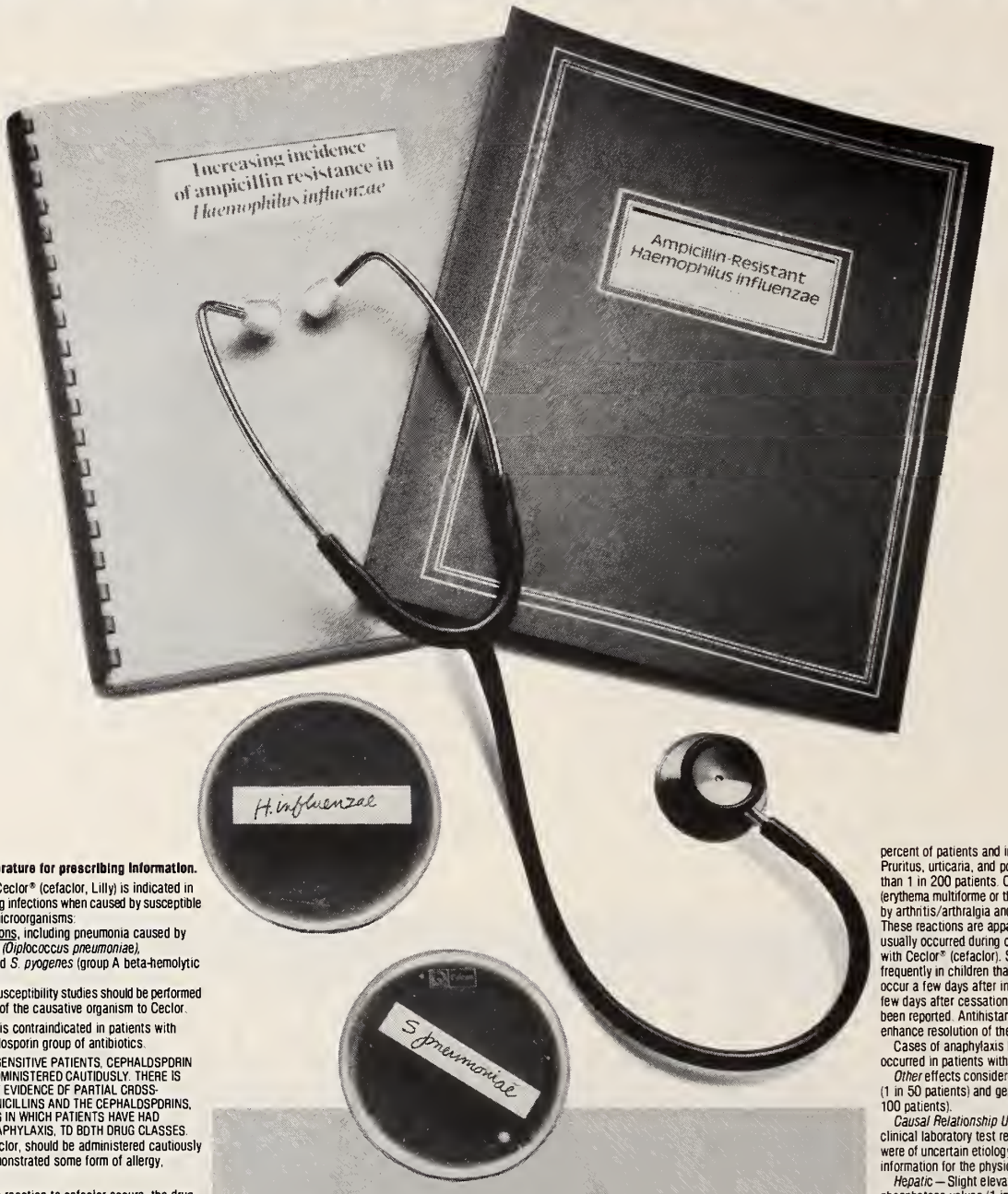
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Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

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Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). 100261

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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J-9043-4 July 1981

A fictional story dealing with the subject of malpractice, including an interesting discussion of the legal interpretations of some of the related Georgia statutes.

A Case of a Good Samaritan

SANDRA C. BROSKY, R.N., *Atlanta**

ACCIDENTS ACCOUNT for a large percentage of all emergencies. Frequently, injuries sustained by the victims are critical and require the immediate assistance of trained medical personnel. Unfortunately, some physicians are reluctant to administer emergency aid for fear of a malpractice suit. This fear is well substantiated; there are more than 5000 actions brought each year.[1] Therefore, with the public welfare in mind, many states have enacted "Good Samaritan" statutes. The statute in Georgia was enacted in March, 1962. Its purpose is to "encourage prompt treatment of accident victims at the scene of the accident."[2] For illustrative purposes, a fictitious story involving an accident is presented below.

The Story

On a Friday afternoon in February, 1980, Jenny Miller, age 27, was leaving a doctor's office. She was 7 months' pregnant with her first child and had gone to see her doctor for a routine checkup. She was somewhat distressed upon leaving the office, because she had been told that due to the baby's position, she might have to have a cesarean section. As she was driving home, she thought about how she would tell her husband. She knew he would be upset that things were not completely okay. All of a sudden, she noticed that the car in front of her had stopped. She slammed on the brakes, and the car started skidding. . . .

The Scene of the Accident

Dr. Alan Windsor was driving to his other office when he saw a man frantically waving at him.

"Please help me," he said. "There's been an accident, and this woman is unconscious." Dr. Windsor went over to see what had happened, and because the woman was pregnant, he thought he should stay with her until the ambulance came. Coincidentally, he was an obstetrician. His colleague, Dr. Lewis Stein, had been with him in the car and advised him against helping because of possible liability in case something went wrong.

"The baby," moaned Jenny, who had momentarily regained consciousness. Alan examined the woman to see if something was wrong and believed that the baby would have to be delivered right away, as it was already crowning. He also noticed some bloody discharge. Jenny lost consciousness again. Dr. Windsor had no idea when the ambulance would arrive, although assistance had been requested 10 minutes earlier. The decision was up to him; he decided to proceed. He readied some instruments he had with him. Since Jenny was unable to assist with pushing, Dr. Windsor used forceps to deliver the baby. With minimal difficulty, the baby was born — but there was an immediate problem. He was not breathing. The ambulance arrived and took over resuscitation efforts, but to no avail. The baby was dead.

Jenny was taken to Green Memorial Hospital and placed in intensive care. When she awoke, she found her husband, Steve, weeping next to her. He told her about the baby. She became furious that Dr. Windsor had taken it upon himself to perform the delivery.

"Why couldn't he have waited for the ambulance to take me to the hospital. Call our lawyer, Steve. I'll make sure Dr. Windsor never delivers another baby."

* Ms. Brosky is an Administrative Resident at Emory University Hospital. Address reprint requests to her at 2493-F Briarcliff Rd., Atlanta, GA 30329.

The Lawsuit

On Monday, April 20, Dr. Windsor received notice of the lawsuit. He fumed. He could not believe it! He called his lawyer, Bill Fine.

"Can you believe this? Here I tried to save both her and her baby, and because of precipitating circumstances, the baby was not spared. How could she possibly think that I caused the baby's death?" He wanted to talk with her, but Bill advised him against it.

"Alan, I know you're upset, but from what you tell me, I feel confident that this situation will be covered by Georgia's Good Samaritan law which states that 'any person . . . acting in *good faith* who renders *emergency care* at the scene of an accident . . . *without making charges* . . . is exempt from any civil liabilities, as a 'Good Samaritan,' as a result of any act or omission.'[3] It will be up to a jury, however, to make the final decision," said Bill.

"What's there to decide," said Alan, "if the law specifically states that I am not liable? I *acted* in good faith and it *was* an emergency, and I certainly *did not* charge her anything."

"The law is only set up as a guideline," Bill said, "and it in no way prevents people from bringing malpractice suits. What it does provide is an excellent defense in a situation such as this. Some of the words used in the statement of the law have vague meanings which allow for flexibility and judgment by an objective party, such as a jury. The term 'good faith,' for example, is an intangible and abstract quality with no technical meaning. It is an honest belief, the absence of malice. An individual's personal good faith is a concept of his own mind and inner spirit and may not be conclusively determined by his protestation alone."[4]

"Bill, that might be the case, but I can't afford a lawsuit. My reputation as a physician will be ruined, not to mention my family's involvement."

"Alan, I can understand your concerns, but studies have shown that the effects of these malpractice actions are not as severe as they might seem to be. One study in particular asked 58 Connecticut physicians, against whom malpractice actions had been brought, how this had affected them. Fifty-two said it had no effect on their practice, five actually noticed an increase in their patients, and only one stated that he had been temporarily injured by the action. Furthermore, no physician lost his license or hospital privileges or even felt compelled to give up his practice as a result of that action. Some did have problems with malpractice insurance rates increasing, but none were denied insurance. Overall, none suffered professionally or socially."[5]

"Well, that makes me feel a little better, but what does this mean: 'charged with *gross negligence*'?"

"Alan, gross negligence implies 'an omission or performance of an action which was the result of a conscious indifference to the rights and welfare of the person affected by it.'[6] This might be difficult to prove because 'in order that there may be negligence, or actionable negligence, there must be some legal duty or obligation on the part of the person against whom the claim of negligence is made.'[7] In addition, expert medical advice is required to establish negligence in malpractice cases. The proper standard or measure for the jury to apply to the acts of a physician to determine whether he exercised a reasonable degree of care and skill must be established by the testimony of a physician, for it is a medical question.[8] This, as you might know, can be difficult to obtain, as many doctors have refused to testify against fellow practitioners charged with negligence. I know of one case, *Agnew v. Parks,*[9] where nine doctors refused to testify for the plaintiff because such conduct was frowned upon, and they feared their malpractice insurance might be cancelled. Recognizing this as a problem, courts in several states have responded to such action by an effort to either 'enlarge the sources of expertise available to the plaintiff or to relax the burden of proof necessary to reach the jury.'[10] Examples of this would be: (1) a general practitioner could be allowed to define the standards to which a specialist should be held, or, alternatively, as the law states in Georgia, any physician in the same specialty in the country could be allowed to define the national standard to which a physician is held;[11] (2) the plaintiff could offer medical treatises to establish professional misconduct;[12] (3) schools of medicine could testify as to the proper treatment practiced by other schools;[13] and (4) the courts could ask you to testify as an expert witness, and this could be used to establish your own misconduct."[14]

The Trial

Later, Alan was thinking back over his conversation with Bill Fine when the baliff said,

"All rise. Court is now in session. Judge William Farmer presiding." Alan could not believe it was already June of 1981. This past year had been traumatic. While the media coverage had apparently not hurt him professionally, he was emotionally drained. The opposing lawyers gave their opening statements, and the trial proceeded smoothly.

Jenny Miller was called to the stand. Based on her testimony, it was not possible to determine why or how the accident had happened, as she testified she did not remember any of the incidents leading up to the accident. Both attorneys questioned her, but to no avail. Alan was disturbed that Jenny's testimony was not more enlightening.

He was more concerned, however, about the issue of negligence. Would the jury find him negligent, or

grossly negligent, as the charges had read? Dr. Stephen King, an ob/gyn specialist, was the next witness called.

"Dr. King," said Bill Fine, "one of the major points to be established in this trial is whether or not this situation constituted an emergency. Are you aware of the legal definition of an emergency?"

"I'm not sure," said Dr. King.

"Well, for your benefit as well as that of the Court, I would like to read the definition from Black's Law Dictionary which states that 'an emergency is a sudden or unexpected occasion for action or an unforseen circumstance that requires immediate attention.'[15] In light of that definition, would you say that this situation was an emergency?"

"Absolutely," said Dr. King.

"The law further states," continued Bill, "that in an emergency which endangers the life or health of a patient, it is the physician's duty,[16] once he voluntarily begins aid, to do that which the occasion demands within the usual and customary practice among physicians and surgeons in the same or similar situations.[17] Dr. King, having had the opportunity to review the facts of the case, what is your opinion about Dr. Windsor's performance on the date in question?"

"After thinking about the situation for several days, I might have waited for the ambulance. My first instinct, however, would have been to act as Dr. Windsor did."

"Dr. King, after examining Mrs. Miller, could you detect any signs of negligence or physical complications with her?"

"I could not find any sign of negligence in Dr. Windsor's actions, and I compliment him on the condition in which he left the plaintiff and on his resuscitation attempts. I also feel that because of the baby's position in utero, it seems the pressure of being delivered under those conditions may have complicated matters, even though the delivery proceeded without much difficulty. If Dr. Windsor had not intervened when he did, I fear the mother may have suffered irreparable bodily damages secondary to the abnormal pressure which the baby imposed in the half-born state and the bleeding which accompanied it." He concluded his testimony by stating that he felt that her accident injuries would not cause any inherent problems with future pregnancies or deliveries.

It seemed to Alan that, at this point, the odds were in his favor. That was until Dr. Paul Raynor, the pathologist, took the stand. Dr. Raynor began by saying that,

"While the cause of the death of the baby was somewhat obscure, it appeared to be due to at least one of several factors. The forceps used by Dr. Windsor could have caused brain damage and the subsequent death of the baby. Even though the forceps had to be used to deliver the child, the bruises found on the head imply that unnecessary pressure was imposed. There was, however, a complicating observation I made during my examination. It seemed that the baby may have aspirated prior to delivery, and while this would certainly have caused his death, it would be hard to prove, since the lungs were so under developed. I do agree with Dr. King in that, because of the crowning, immediate intervention was necessary.

Alan took the stand next. He testified that he felt that it was his *moral* obligation to help Jenny, as she was obviously in such distress. The direct questions and cross examination continued for another hour. Judge Farmer then recessed court until the following morning.

Dr. Windsor's anxiety mounted once again as he listened to the closing arguments of Jenny's attorney. He was not only asking for damages secondary to professional incompetence but emotional damages as well. The jury's faces were expressionless as Bill got up to give his speech.

"While the testimony you've heard has been conflicting, I would hope that you would bear in mind the following. 'When one is confronted with a sudden peril requiring instinctive action, he is not, in determining his course of action, held to the same degree of care as when he has time for reflection.'[18] In addition, he is not liable, if while exercising his best judgment, his efforts to assist nature do not bring about the desired result."[19] Bill continued by saying that, "'the law imposes no duty on one person to actively assist in the preservation of the person or property of another from injury even though the means by which harm can be averted are in his possession. The law thus recognizes that there is no general duty to come to the assistance of a person who cries for help from an overturned canoe in deep water; there is no general duty to rescue a person who is in peril. It is the feelings of kindliness and sympathy which may move the Good Samaritan to minister to the needs of the sick and wounded at the roadside, but the law imposes no such obligation, and suffering humanity has no legal complaint against those who pass by on the other side.'[20] Should Dr. Windsor, who out of the goodness of his heart and moved by his moral conscience, be found guilty of an act of goodwill, of a decision which he made based on clinical expertise and personal judgment? Unfortunately, those duties which are dictated by good morals or by humane considerations are not within the domain of the law,[21] but I hope that after having heard the evidence presented here today that you will find that Dr. Alan Windsor did act in good faith and is therefore not guilty as charged."

While it seemed an eternity, the jury returned after 4 hours.

"Have you reached a decision?" asked Judge Farmer. When the foreman of the jury answered affirmatively, the Judge said,

"Will the plaintiff and the defendant please rise." He then read the verdict, "We, the jury, find Dr. Alan Windsor, not guilty as charged."

Alan shook Bill's hand and started towards his family. He was thankful and relieved that it was over.

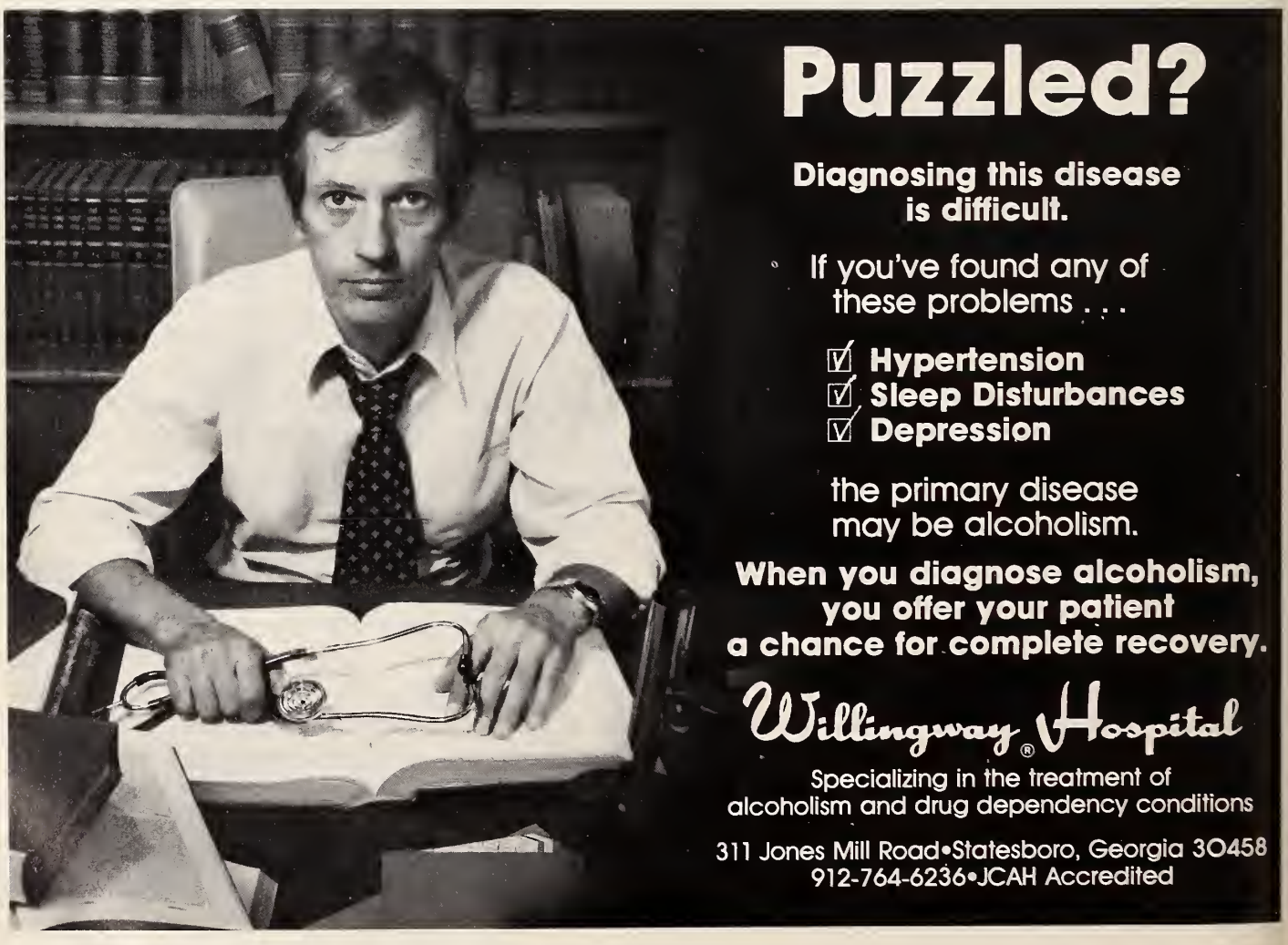
Acknowledgement

The author would like to thank Mr. Bob Berg, an associate with the law firm of Powell, Goldstein, Frazer & Murphy for his assistance with this article.

(Editor's Note: In this month's "Legal Page," Mr. Thomas Harper discusses "The Joys of Malpractice Trials — And How To Avoid Them." As an adjunctive paper, it provides additional insight into the subject of malpractice.)

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12. Good samaritans and liability for medical malpractice. Columbia Law Review 1964;64:1304.
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16. *Code of Georgia Annotated,* Book 24, Titles 82-84. Norcross: The Harrison Company, 1979, 154, (Code 84-924).
17. *Ibid,* p. 154.
18. Black H. *op cit,* p. 469.
19. See, *Howell v. Jackson,* 65 *Georgia Appeals* 423 (1971)
20. *American Jurisprudence,* Vol. 57, 2nd ed, Rochester: West Publishing Company, 1971, 389.
21. *Ibid,* p. 389. See also *Ibid,* p. 394. "If a person takes charge of another who is helpless or can't protect himself, he is liable for personal injuries to such other through failure to exercise reasonable care for the other's safety or if by discontinuing his aid or protection, he has left the other in a worse position than when he took charge."



The Joys of Malpractice Trials — And How to Avoid Them

THOMAS D. HARPER, *Atlanta**

THE SEEMINGLY ENDLESS stream of law school graduates produced by this nation's universities has resulted in a massive increase in litigation on all matters of public and private concern. The medical profession has not been immune from this mass of civil actions, and the specter of medical malpractice litigation looms over the practice of every physician.

Without regard to the merits of a particular action, civil litigation is extremely time consuming and expensive. As a result, legislatures and the courts have recognized the necessity of restricting the unnecessary intrusion into a physician's practice and have established certain safeguards to protect the interests of the physician while at the same time permitting the prosecution of valid claims. For example, in cases in which physicians serve solely as witnesses, depositions are generally used in lieu of testimony at trial, thereby allowing physicians to avoid the uncertainties of time inherent in any trial and the resultant turmoil in a doctor's schedule. In contrast, lay witnesses are simply told, "Be ready when we call." In cases in which physicians are named defendants, equivalent accommodations are afforded which are unavailable to other professionals.

The expense of litigation necessarily imposes upon realistic defendants a willingness to pay in cases where the merits alone would not warrant any such payments. As a consequence, "nuisance settlements," the payment to an undeserving plaintiff of an amount approximating the cost of defending the claim as a means to avoid the trouble inherent in a full-scale defense, have grown increasingly common. Payment under such circumstances, however, encourages the filing of additional, baseless actions. The courts and legislatures have recognized this problem and have attempted to establish a framework for a physician to avoid a trial and thereby eliminate the necessity for entering into nuisance settlements with nondeserving patients.

Pre-Trial Summary Defenses Available to Malpractice Defendants

After the service of a complaint and referral to the insurance carrier, a physician's counsel is presented several procedural means to avoid a full-scale trial. If the complaint establishes that a recovery would not be authorized under any conceivable set of circumstances, a "motion to dismiss for failure to state a claim" may be filed.[1] However, in the vast majority of cases, medical malpractice litigation arises out of acts of negligence which are alleged in the complaint and, consequently, a motion to dismiss is rarely appropriate. For this same reason, a

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second possible summary defense, the "motion for judgment on the pleadings," is similarly unavailing.[2] Judgment on the pleadings would be appropriate if the complaint alleges specific facts which establish that the claimant is not entitled to a recovery. For example, a complaint filed in 1981 alleging that an injury occurred in 1961 would be subject to a motion for judgment on the pleadings as violative of the applicable statute of limitations.

The most common means for the avoidance of a trial is the motion for summary judgment. This motion is appropriate if there is no dispute as to material facts, and under those facts, the defendant is entitled to judgment as a matter of law.[3] In the context of malpractice actions, a motion for summary judgment would be appropriate in several instances as a result of the determinations by the federal and state legislatures that considerations of general public benefit limit or totally preclude recovery against a physician.

A statute of limitations, for example, is simply a legislative recognition of the fact that the passage of time alone should immunize a physician from any civil action. The existence of actual negligence is irrelevant if suit is not initiated within the required time. In Georgia, a specific statute of limitations applicable only to medical malpractice actions provides that a complaint must be filed within 2 years after the allegedly negligent or wrongful act occurred.[4] In many instances, this statute establishes a shorter period for malpractice actions than applies in cases involving any other issue.[5]

The circumstances under which assistance is rendered may also bar the prosecution of a civil action. The legislature has recognized the general public benefit which accrues from encouraging voluntary emergency care and has immunized from liability any person who, in good faith and without charge, renders care at the scene of an accident or emergency.[6] Under the proper factual showing, a physician is immunized from liability even if he or she has been negligent.

Although a court is granted wider discretion on a directed verdict than on a motion for summary judgment, it is not proper to direct a verdict for a plaintiff in a medical malpractice action.

As opposed to cases involving the basis or timeliness of the claim, a substantial number of cases require an inquiry into the merits of the action: whether or not treatment was negligent. Even in these cases, however, summary judgment may be available to the physician defendant.

Negligence generally entails a violation of a duty owed to another. In malpractice cases, the rules concerning a physician's duty of care, and a violation thereof, are uniquely favorable to the medical profession. A physician's duty to his patient is established in Georgia by a disarmingly simple provision: "A person professing to practice surgery or the administering of medicine for compensation must bring to the exercise of his profession a reasonable degree of care and skill." The required degree of care and skill is that which, under similar conditions and like circumstances, is ordinarily employed by the profession in general.[7]

The courts of Georgia have interpreted this provision in a manner which has made it impossible for many complaining patients to create a factual issue and thereby obtain a trial on the merits. This results, at least in part, from a judicial recognition of the special consideration to be afforded physicians.

The law recognizes that medicine is an inexact science at best and that a physician is limited to merely assisting nature in accordance with the present state of medical experience. The law also presumes that medical services are performed in a skillful manner. This presumption arises from the recognition that a doctor is not an insurer and that an unintended result does not raise even an inference of negligence.[8]

More importantly, with respect to the availability of summary judgment to a physician defendant, the proper measurement of a physician's compliance with his

duty of care can be established only by the testimony of physicians, for it is a medical question. Physicians are accorded special treatment in this respect: expert testimony is not required against non-doctor defendants.[9] In the vast majority of medical malpractice claims, a plaintiff simply cannot prevail in the absence of expert testimony.[10]

A physician may satisfy the burden imposed upon a movant for summary judgment by the presentation of an affidavit from an expert establishing that the requisite standard of care was met in the instance under inquiry. In fact, the necessary testimony may be provided by the physician himself.[11] A plaintiff, in rebuttal of such an affidavit, must present specific expert testimony: Unlike the physician, his own affidavit is not enough. If the plaintiff obtains an expert witness, the witness must specifically state that the proper standard of care was not attained in the treatment at issue. A mere difference in practice or views among physicians does not authorize a judgment against a treating physician.[12]

Even if a plaintiff is able to establish a negligent act, the burden of proof is further compounded by the obligation to establish that the negligent act is the legal cause of an injury of which a party complains. The negligent treatment and the actual injury must be connected in a manner establishing a relationship sufficient to authorize relief for the plaintiff.[13]

Other Summary Defenses Available to the Malpractice Defendant

Even in the unfortunate circumstance where a trial is necessary, a "motion for directed verdict" may be available to a physician defendant upon the conclusion of a plaintiff's case. A verdict may be directed for the defendant where, without weighing the credibility of the witnesses or otherwise considering the weight of the evidence, there can be but one conclusion as to the verdict that reasonable men could reach. Thus, a court may direct a verdict for the physician defendant in a malpractice case if the court believes that, regardless of any defenses alleged by the defendant, the jury could not reasonably grant a verdict to the plaintiff on the basis of his or her case.

A court is granted wider discretion on a directed verdict than on a motion for summary judgment. This discretion does not extend to the directing of verdicts against a defendant physician, however. It is not proper to direct a verdict for a plaintiff in a medical malpractice action.[14]

Conclusion

Physicians are accorded a role of special esteem in American life and that unique position is reflected in the judicial standards applied to judge their conduct. The courts permit physicians to be judged by physicians, and the right of a plaintiff to obtain a trial by jury has been limited in malpractice actions to a degree not attained in other equivalent realms of the law. The special responsibility borne by physicians has given rise to this special status and, consequently, special protection in the exercise of their unique rights and obligations.

Notes

1. Ga. Code Ann. §81A-112(b)(6); Fed.R.Civ.P. 12(b)(6).
2. Ga. Code Ann. §81A-112(c); Fed.R.Civ.P. 12(c).
3. Ga. Code Ann. §81A-156; Fed.R.Civ.P. 56.
4. Ga. Code Ann. §3-1102.
5. See, for example, *Hamby v. Neurological Associates, P.C.*, 243 Ga. 698, 256 S.E.2d 378 (1979).
6. Ga. Code Ann. §84-930. See, Berg RN. Not-so-good news for the Good Samaritan. JMAG 1980; 69(3), 229-231.
7. Ga. Code Ann. §84-924.
8. *Blount v. Moore*, 159 Ga. App. 80, 81, 282 S.E.2d 720 (1981); *Hayes v. Brown*, 108 Ga. App. 360, 363, 133 S.E.2d 102 (1963).
9. *Hawkins v. Greenberg*, 159 Ga. App. 302, 306, 283 S.E.2d 301 (1981); *Skinner v. Coleman Nincic Urology Clinic*, 156 Ga. App. 638 n.1, 275 S.E.2d 724 (1981). *Compare Savannah Valley Production Credit Ass'n. v. Cheek*, No. 38095 (Ga., invariably apply to all malpractice actions).
10. *Howard v. Walker*, 242 Ga. 406, 407, 249, S.E.2d 45 (1978).
11. *Parker v. Knight*, 245 Ga. 782, 783, 267 S.E.2d 222 (1980).
12. *Robertson v. Emory University Hospital*, 611 F.2d 604, 606 (5th Cir. 1980); *Mayo v. McClung*, 83 Ga. App. 548, 556 64 S.E.2d 330 (1951).
13. *Maddox v. Houston County Hospital Authority*, 158 Ga. App. 283, 284, 279 S.E.2d 732 (1981); *Parrott v. Chatham County Hospital Authority*, 145 Ga. App. 113, 115, 243 S.E.2d 269 (1978).
14. Ga. Code Ann. §81A-150; Fed.R.Civ.P. 50. See, *Hawkins, supra*, 159 Ga. App. at 306.

(Editor's note: The subject of malpractice litigation is discussed in another paper in this issue of the Journal. *"A Case of a Good Samaritan," by Sandra Brosky, R.N., is a fictional story of a doctor assisting at the scene of an automobile accident and the subsequent lawsuit brought against him.)*

editorial
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editorial

No Easy Way

THE FRESH, new beauty of spring, with its lush, silent explosion of flower and tree blossoms, is here. This is a time when we can renew our own spirits as we participate in the renewal of nature around us. Spring is a time of new beginnings, with the fulfilled promise in nature that new life does indeed follow apparent "death." No matter how bitter the winter, there is always a spring.

For Christians, spring is the season of the Easter celebration which, along with its joys, brings to mind the suffering and death of Jesus Christ at the time of his crucifixion.

Suffering is an enigmatic paradox of life that yet *commands* our attention and understanding. As physicians, we are inevitably involved with individuals and their families who experience acute or prolonged suffering. In spite of the technical advances in pain allaying medications, we sometimes find ourselves powerless in our efforts to relieve physical and emotional pain in our patients.

How do we respond to the suffering of others? How should we?

If we are to believe the observations of truly wise men through the ages, we are persuaded to view suffering as a growing and maturing experience and as a necessary part of life. We ought to view suffering in others (and in ourselves) not as something from which to escape but to relate to positively. Rather than evading this reality, we should as a part of our own growth accept these events as a part of the flow of life.

The acceptance of suffering as an element of life does not diminish the responsibility we have to alleviate its causes. Yet we must recognize that suffering contributes to the meaning of life.

Napoleon, while exiled on the island of St. Helena, remarked, "It requires more courage to suffer than to die." Certainly we see many of our patients relieved of bodily pain by death. But what of those who live either in chronic physical or emotional pain, or with some other sort of disability or handicap? Often, especially when we are in the first years of our practice, we may consciously or subconsciously regard incomplete or "marred" recoveries as somehow reflecting failure on us as physicians. Consciously or not, we may find it personally painful to continue to treat a sick patient who does not respond to the best therapy we are able to provide. We may want to avoid facing this failure — either as perceived to be in ourselves or in our sick patients — and tend to withdraw from the close interface we normally have.

It is imperative for us to come to an understanding of the enobling effect that suffering can have on the soul before we can effectively address the emotional and physical needs of our patients.

We can come to such an understanding as a result of our experiencing the paradoxical growth associated with suffering. It is analogous to the pruned vine that subsequently thrives. Our understanding is not something that can be derived by intellectual or empirical means.

There is no easy way. If we cannot come to grips with our own suffering or that of our patients, we postpone the inevitable transformation within ourselves that enables us to see suffering as an ineluctable part of life. To deny this is to deny an essence of our humanity — and to deny that precludes much of the inner growth available to us. By such an unfortunate choice, we play only with the surface phenomena of life.

The depth of meaning for which many people search can be found only in a simple acceptance of the totality of life — with its joys *and* agonies, its good *and* bad, its fruitfulness *and* barrenness. Such acceptance need not — and must not — be maudlin or depressing. Ultimately, it frees us.

Edgar Woody, Jr., M.D.

Acute Lymphocytic Leukemia in Childhood

CARLOS S. ALVARADO, M.D., TAE KIM, M.D., and
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Introduction

ACUTE LYMPHOCYTIC LEUKEMIA (ALL) is the most common malignant disease in childhood and accounts for 80% of the acute leukemias in children. Once regarded as invariably fatal, the outlook for children with this disease has demonstrated a remarkable improvement in the past 20 years with the advent of modern chemotherapy. Today, a large number of patients remain in a prolonged disease-free survival status, and nearly 50% of all newly diagnosed cases will eventually be "cured."[1] These results are due to better supportive care, the use of superior chemotherapy programs, and the prevention of involvement of the central nervous system (CNS).

Diagnosis

ALL affects approximately 1 out of 3000 children each year; the peak age of incidence is between 2 and 6 years, and it is more common in boys than in girls. Also, beyond the first year, the disease occurs twice as often in whites as in blacks. Although the etiology remains unknown, leukemia is believed to be neither contagious nor hereditary.

The symptoms and signs of ALL reflect two basic pathogenic mechanisms: 1) bone marrow failure, due to displacement of normal hematopoietic elements by the leukemic cells, and 2) infiltration of extramedullary tissues. Clinically, it is characterized by a protean symptomatology that may present abruptly or insidiously. The disease should be suspected in a child with a persistent febrile illness not responding to treatment, in the presence of unexplained malaise, anemia, thrombocytopenia, bone pain, or arthralgias. In one large series of patients,[2] the most common presenting symptoms were fever (61%), pallor (55%), anorexia (33%), fatigue (30%), bone pain (23%), abdominal pain (19%), joint pain (15%), lymphadenopathy (15%), and weight loss (13%).

The diagnosis of ALL is often suggested by an abnormal blood count. In the classic case, the peripheral smear reveals leukocytosis, anemia, thrombocytopenia, and the presence of lymphoblasts. It must be remembered, however, that one third of the patients may have a normal white blood cell (WBC) count and that 15% will present with a normal hemoglobin value. Therefore, a diagnosis of ALL can only be firmly established or discarded by a bone marrow aspirate. This is usually hypercellular and shows abundant blasts; a few myeloid or erythroid precursors may be seen, but megakaryocytes are usually absent.

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The differential diagnosis includes four main entities:

1) Infectious mononucleosis, which commonly presents with fever, adenopathy, visceromegaly, and lymphocytes closely resembling blasts (atypical lymphocytes) in the peripheral blood. A positive heterophil test, abnormal liver function tests, and the heterogenous appearance of the lymphocytes suggest the correct diagnosis, so that a bone marrow aspirate to exclude leukemia is rarely necessary.

2) Aplastic anemia is an important cause of pancytopenia. Unlike ALL, in this disease neither adenopathy nor visceromegaly are seen, and the bone marrow is hypocellular without increased blasts.

3) ITP. In this disease the hemorrhagic manifestations predominate (purpura, epistaxis, etc.), but the child is otherwise in good condition, and the white cells and hemoglobin are usually normal. A bone marrow aspirate reveals only increased megakaryocytes.

4) Juvenile rheumatoid arthritis (JRA) may be confused with ALL, for it, too, may present with fever, mild anemia, adenopathy, and splenomegaly. On the other hand, in 15-20% of ALL cases, arthralgias and arthritis so dominate the picture that an erroneous diagnosis of JRA is made. Therefore, a bone marrow aspirate should be done in patients with the diagnosis of JRA unresponsive to salycilates or running an atypical course before starting them on corticosteroids.

Classification and Prognostic Factors

Acute lymphocytic leukemia is a heterogenous disease. Certain clinical and laboratory characteristics relate to response to treatment and final outcome. Thus, a group of ''poor risk'' ALL patients has been identified by the following characteristics: a high WBC count ($>20,000/mm^3$), under 2 or over 10 years at the time of diagnosis, male, black, presence of a mediastinal mass, CNS involvement, massive adenopathy, and hepatosplenomegaly. Of these, WBC count and age at diagnosis are the most important criteria of prognosis. Patients lacking these have been found to have the best prognosis and constitute the ''favorable'' group.

Immunologic studies on the lineage of the leukemic blast cell have so far revealed four distinct ALL subtypes with varying prognostic significance:

1) T-cell ALL (12%), characterized by a thymus-related antigen (T-antigen) and/or the ability to form rosettes with sheep erythrocytes;

2) B-cell ALL expresses B-cell characteristics (surface immunoglobulins) and comprises 2-3% of all cases;

3) Null-cell ALL (non-T, non-B) which expresses neither T nor B cell surface markers, but rather the common-ALL antigen. This group makes up the majority (65%) of childhood ALL;

4) A newly recognized type Pre-B cell ALL, defined by the presence of cytoplasmic (but not surface) immunoglobulins; it accounts for 18% of ALL cases.

The prognostic value of these immunologic subsets is demonstrated by the positive correlation they bear with the clinical and laboratory features associated with prognosis. Thus, T-cell leukemia, which has a poor prognosis, is usually characterized by an extremely high WBC count and occurs mainly in boys over 10 years of age with a mediastinal mass. On the other hand, Null-cell and Pre-B cell ALL usually lack these features and have a better prognosis.

A morphologic classification proposed by a collaborative French-American-British group[4] divides ALL into three groups according to predominant blast morphology: L1, L2, and L3. The prognostic value of this classification has been suggested by some, since patients with Ll-ALL appear to fare significantly better than those with L2 or L3 morphology. L3 morphology is associated with B-cell leukemia.

Recent chromosomal studies done on patients with ALL have shown that a small number are Philadelphia chromosome positive.[5] These seem to represent yet another subset of patients characterized by an unfavorable prognosis.

Management

The improved results in the treatment of ALL are in part due to the progress made

in the area of chemotherapy and supportive care.[6]

1) **Supportive Care —** Both at diagnosis and during the entire period of treatment, the leukemic child is threatened by the consequences of bone marrow failure and myelosuppression induced by chemotherapy. Thus, in the neutropenic child, fever often signifies bacterial infection and calls for the prompt institution of broad-spectrum antibiotic coverage once specimens (blood, urine, secretions, etc.) are cultured. Preventive measures (care of indwelling catheters, optimal oral hygiene, etc.) are extremely important. Also, the use of absorbable antibiotics such as the combination of sulfamethoxazole/trimethoprim (Bactrim) has been, in our experience, of great value in lessening the incidence of bacterial infections in children with cancer. Transfusion of granulocytes is another valuable means of fighting infections, but we restrict its use to patients with documented septicemia not responding to appropriate antibiotic therapy. Although the risk of bacterial infections goes beyond the initial phase of treatment, infections due to viral, fungal and, opportunistic organisms become a significant cause of morbidity and mortality during remission. Common viral illnesses, such as varicella, can be overwhelming and fatal. Varicella can now be prevented by the administration of zoster immunoglobulin (ZIG), now commercially available, within 48 hours of exposure. Among the opportunistic infections, *Pneumocystis carinii* pneumonia was until recently a common cause of death in leukemic children. Here, too, the routine use of Bactrim in our patients has resulted in a dramatic decline in the incidence of this complication.

Bleeding due to thrombocytopenia is another serious problem. Because of the increased risk of alloimmunization and the unproven value in our institution of prophylactic platelet transfusion, we use platelet transfusion only in patients with active bleeding and in those with severe thrombocytopenia and ongoing infections.

Another important aspect of supportive care concerns the prevention and treatment of electrolyte imbalances (hyponatremia, hypokalemia, hypocalcemia, etc.) and hyperuricemia which are often present at initial diagnosis or during relapse. Hyperuricemia results from rapid catabolism of purine nucleotides and when untreated can lead to acute renal failure. The use of large amounts of parenteral fluids at the onset of therapy, along with allopurinol and urine alkalinization usually prevents uric acid nephropathy.

2) **Chemotherapy —** Modern treatment of ALL implies multiple agent chemotherapy and consists of three distinct phases:

a) Induction of bone marrow remission is designed to drastically reduce the number of leukemic cells and restore normal hematopoiesis. With the combination of vincristine and prednisone, 90% of patients attain remission.[6] The use of L'Asparaginase during induction raises the induction rate to 95% and seems to prolong survival.

b) CNS prophylaxis is aimed at killing the leukemic cells that may have escaped the action of systemic drugs during induction or that may seed into the CNS during remission. Effective prophylaxis is now achieved either by cranial irradiation plus 5 intrathecal doses of Methotrexate or by triple intrathecal drugs (Methotrexate, ARA-C, hydrocortisone) given intermittently throughout the treatment period. The value of CNS prophylaxis as part of the treatment program of ALL cannot be overemphasized, for it has resulted in a dramatic decline in the incidence of CNS involvement (from 50% to less than 10%) and thus has played a major role in improving long-term prognosis.

c) Maintenance therapy seeks to prevent relapse or disease recurrence. The best drug combination for this phase is 6-Mercaptopurine and Methotrexate. These drugs are administered orally and have minimal toxicity. The periodic use (''pulse treatment'') of prednisone alone or prednisone plus vincristine is thought to enhance the effectiveness of Methotrexate and 6-Mercaptopurine in this phase of treatment.

While the ideal duration of chemotherapy is still debatable, most centers have elected to treat children with ALL for 2½ to 3 years. Our own policy is to discontinue chemotherapy after 3 years of continuous complete remission.

Despite the improvement of chemotherapy, a number of patients still relapse while on maintenance therapy or after it has been stopped. The most common sites of relapse are the bone marrow, the testes, and the central nervous system. In every instance, relapse considerably diminishes the chance of lengthy survival for the patient.

Improved Survival

Before the era of modern chemotherapy, most leukemic children died within 6 months of diagnosis, and very few survived to 12 months. The outlook is now much brighter, since prolonged disease-free survival is now the rule and "cure" is a realistic goal for close to 50% of patients.

Also, the prognosis for T-cell leukemic patients has improved since they are being treated with a modified non-Hodgkins lymphoma chemotherapy program. A preliminary evaluation of the results revealed 90% induction rate and close to 50% survival at two years of treatment. These results compare favorably with those attained when these patients were treated with a regular leukemia protocol.

As to the relapsing patients, they can be easily re-induced with prednisone and vincristine, and some of them can be maintained in remission and even be taken off therapy. The improved management of CNS leukemia in recent years has resulted in total eradication of the disease in a considerable number of patients.

Over the past decade, bone marrow transplantation has become an effective therapeutic alternative for acute leukemia. This form of treatment is now being increasingly offered to those children with ALL attaining a second remission who have a HLA compatible, MLC-identical sibling. Due to improved conditioning of the patient and management of complications related to the transplant itself (graft versus host disease, pneumonia, interstitial pneumonitis), a 5-year survival rate of 60% has been recently projected for patients receiving an allogeneic bone marrow transplant.[7] Even when refractory patients with ALL receive a syngeneic bone marrow transplant, a median survival of 80 months for one fourth of them has been reported.[8]

New Directions

One of the tasks for the next years will continue to be the evaluation of newly designed treatment protocols in the hope of finding the ideal treatment for each particular risk category of patients. The basic idea will remain the same: the use of the most effective chemotherapy program with the least toxicity for the appropriate length of time.

Because of its significant incidence and ominous prognosis,[9] the problem of testicular relapse will deserve special consideration. There is now consensus on the value of doing testicular biopsies in all patients going off treatment, and a recent study[10] has suggested the importance of performing biopsies of testes at the time of diagnosis of ALL before starting induction chemotherapy. This study found a rather high incidence of leukemic infiltrates (20%) at diagnosis and, interestingly enough, it showed that, except for T-cell patients, induction chemotherapy is effective in clearing the leukemic infiltrates, a finding that seems to negate the "blood-gonad barrier" theory of testicular leukemia. Hopefully, this new knowledge will help in the design of a more effective therapeutic approach to the problem.

Efforts will also be directed to refine our current methods to detect occult disease during the period of remission in order to adjust therapy in terms of length and modality to the needs of each patient.

(References are listed on page 271.)

The Use of Echocardiography in the Diagnosis and Treatment of Acute Myocardial Infarction

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ECHOCARDIOGRAPHY is a useful noninvasive technique in the evaluation of patients with coronary atherosclerotic heart disease (CASHD). Standard M-mode and the newer two-dimensional echocardiographic methods have a definite role in the initial evaluation and subsequent follow up of patients with known or suspected CASHD. M-mode echocardiography is especially useful in the differential diagnosis of chest pain, whereas two-dimensional echocardiography is useful in determining the presence and extent of wall motion abnormalities in patients with CASHD.

Echocardiography has many desirable attributes for diagnostic and research studies in patients with acute myocardial infarction (AMI). It does not alter the physiologic state being evaluated, is relatively inexpensive, and does not interfere with other hospital procedures. For these reasons, the test may be repeated frequently, even on extremely ill patients, and it can assess and serially follow left ventricular function. Furthermore, echocardiography is useful in evaluating many of the complications of AMI.

M-Mode Echocardiography

Differential Diagnosis of Chest Pain — Several disorders other than CASHD may cause chest discomfort. These diseases include valvular aortic stenosis, idiopathic hypertrophic subaortic stenosis (IHSS), and mitral valve prolapse. Echocardiography is extremely valuable in establishing the diagnosis of these lesions. Patients with CASHD, on the other hand, have echocardiograms that are frequently characteristic but rarely diagnostic.

Analysis of Left Ventricular Wall Motion — Useful information about left ventricular volume, diastolic pressure, and segmental wall motion may be obtained by echocardiography. Although a definite diagnosis of AMI cannot be made, abnormalities of wall motion may occur early and support a clinical impression of infarction.

Echocardiography can be used to examine a variety of areas of the left ventricle and is particularly sensitive in defining motion of individual wall segments. The detection of ischemic myocardial damage by echocardiography is based on the

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almost instantaneous loss of regional left ventricular wall motion that occurs after the onset of ischemia. Abnormal ventricular septal motion is frequent in patients with anterior AMI, whereas abnormalities of the left ventricular free wall occur in those with inferior AMI. In addition, there is a high incidence of increased wall excursion (compensatory hyperdynamic motion) in the noninvolved areas of the myocardium. Although these echocardiographic features have a high degree of specificity, their sensitivity is limited.

A lack of contractile function of the involved myocardium is one of the earliest changes in AMI and is additional evidence of scarred ischemic myocardium. This results in thinning of a segment of myocardium and inadequate or absent systolic thickening of the septum or posterior left ventricular wall. Although systolic thinning is seen almost exclusively in patients with infarction, this finding is not completely specific for AMI as it has been observed in some patients with chronic coronary heart disease. Furthermore, not all patients with infarction exhibit systolic thinning. Follow-up studies of patients with AMI have shown that these wall motion abnormalities usually decrease with time, but abnormal excursion and decreased thickening of the involved wall persist in many cases. Except for the almost exclusive finding of wall thinning in patients with infarction, the echocardiogram alone cannot distinguish acute from chronic coronary disease, nor can it reliably distinguish patients with congestive cardiomyopathy and other diseases of the myocardium from those with CASHD.

Echocardiography is especially useful in distinguishing pericardial effusion from left ventricular enlargement in the patient with an enlarged cardiopericardial silhouette on chest x-ray examination.

There are many limitations in evaluating wall motion by M-mode echocardiography because every area of the left ventricle cannot be adequately examined. The M-mode echocardiographic findings in AMI appear to be principally dependent on the position of the infarcted area relative to the echo beam. In addition, because coronary disease affects only segments of the myocardium, multiple areas of the septum and free wall must be recorded before the echocardiographic evaluation can be considered adequate. If the acutely infarcted area of the ventricle is remote from the area recorded, the findings are nonspecific and relate primarily to depressed myocardial contractility or compensatory increases in wall motion. If the echo intersects a hypermobile, noninfarcted segment or hypomobile, infarcted segment of the myocardium, the end-systolic and end-diastolic dimensions will not reflect the changes in the volume of the ventricle as a whole. Even if the echo beam transects an area of infarction, this segment may be pulled in a normal direction by adjacent, viable myocardium. Abnormally moving, ischemic muscle may affect immediately adjacent, normal myocardium by reducing its motion, even though that muscle may still be normal. Furthermore, it is difficult to quantitate the amount of abnormally moving wall, especially in the septum, since a distorted impression is obtained of the amount of septum being examined. M-mode echocardiography cannot even consistently distinguish patients with CASHD from normal subjects, since many patients with severe obstruction of a coronary artery have normal left ventricular function at rest. *Thus, the primary purpose of M-mode echocardiography in a patient with chest pain, whether or not it is typical of angina pectoris, is to detect the cause of ischemia other than atherosclerotic obstruction of the coronary artery, such as IHSS, mitral valve prolapse, or aortic valve disease.*

Analysis of Left Ventricular Function — The M-mode echocardiogram provides valuable information about the function of the left ventricle that is unavailable from physical examination, standard x-ray examination, ECG, or angiography. Serial evaluation of the left ventricle in patients with heart disease frequently helps to detect alterations in left ventricular contractility even before symptomatic de-

terioration occurs. The most important parameters used to evaluate left ventricular function include internal diameters of the left ventricle, percent change in left ventricular internal diameter (percent delta D), ejection fraction, excursion of the ventricular walls, and velocity of circumferential fiber shortening. When there is ventricular involvement, however, as occurs with CASHD, the area of the ventricle examined by the standard echocardiographic approach may no longer be representative of the entire ventricle.

Two-Dimensional Echocardiography

Two-dimensional echocardiography, a relatively new noninvasive technique, provides highly useful information about regional and global left ventricular anatomy and function by delineating tomographic cross sections of the heart. It can be used to evaluate left ventricular abnormalities at rest and to study stress-induced reversible ventricular dysfunction. Since larger areas of the left ventricle can be visualized by this techinque, and it is well tolerated by critically ill patients and can be performed at the bedside, two-dimensional echocardiography is suitable for sequential studies in patients with AMI. Complete left ventricular visualization can be obtained in 85 to 90% of patients, allowing qualitative assessment of left ventricular anatomy and function. Quantitative analysis of regional and global left ventricular function and calculation of volumes and ejection fraction are feasible if technically high quality studies are obtained. Two-dimensional echocardiography, therefore, has some clear advantages over M-mode echocardiography: (1) it can gather and display anatomic data in a form familiar to all physicians; (2) its spatial characteristics are such that target recognition is greatly enhanced, resulting in rapid and accurate identification of valves and chambers; and (3) it permits the determination, location, and extent of regional asynergy.

Complications of Acute Myocardial Infarction

Many complications of AMI can be accurately assessed by M-mode and two-dimensional echocardiography. Since echocardiography can evaluate regional and overall left ventricular performance, it can be used as an index of left ventricular function to aid in identifying patients at risk for developing overt pump failure.

Rupture of the ventricular septum results in acute right and left heart failure, usually associated with an increase in size of the right ventricle that may be detected by M-mode echocardiography. Two-dimensional echocardiography combined with injection of contrast material (contrast echocardiography) can demonstrate "bubbles" moving across a ventricular septal defect.

The M-mode echocardiogram is useful in following patients with pericarditis to detect the presence and amount of pericardial fluid and to identify potential compression of ventricular chambers. Echocardiography is especially useful in distinguishing pericardial effusion from left ventricular enlargement in the patient with an enlarged cardiopericardial silhouette on chest x-ray examination.

Two-dimensional echocardiography, with its ability to image the left ventricular apex, has proved to be both reliable and sensitive in detecting ventricular aneurysm; correlation with angiographic findings is excellent. Detection and characterization of a ventricular thrombus with two-dimensional echocardiography is also now possible.

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. . . in infants and children

Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).[1]

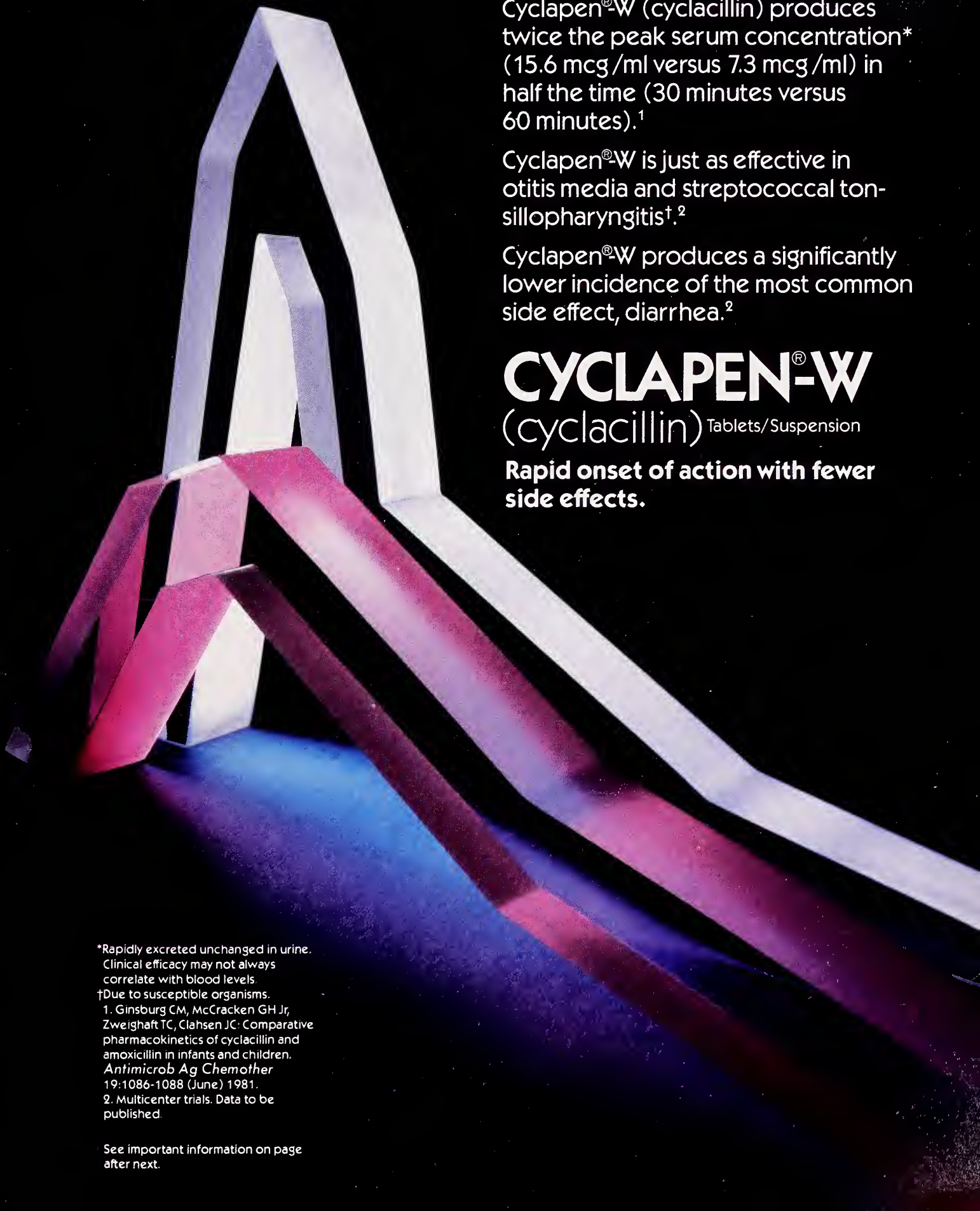
Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.[2]

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.[2]

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(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.



*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

See important information on page after next.

Compared to ampicillin

Faster peak. Fewer problems.

. . . in adults and children



Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.[3]

Cyclapen®-W is just as effective in otitis media, bronchitis, pneumonia, urinary tract infections and infections of skin and skin structures†.[3]

Cyclapen®-W produces a significantly lower incidence of diarrhea and skin rash.[3]

CYCLAPEN®-W

(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.
†Due to susceptible organisms.
3. Data on file. Wyeth Laboratories.
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See important information on adjoining page.

Wyeth Laboratories
Philadelphia, Pa 19101

Cyclapen®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indicatians: Treotment of the following infections:

RESPIRATORY TRACT
Tonsillitis and phoryngitis coused by Group A beto-hemolytic streptococci
Bronchitis and pneumonio coused by S. pneumaniae (formerly D. pneumanioe)
Otitis medio coused by S. pneumonioe (formerly D. pneumonioe) and H. influenzae
Acute exocerbotion of chronic bronchitis coused by H. influenzoe*
*Though clinicol improvement has been shown, bocteriologic cures connot be expected in oll potients with chronic respirotory diseose due to H. influenzoe.

SKIN AND SKIN STRUCTURES (integumentory) infections coused by Group A beto-hemolytic streptococci ond stophylococci, nonpenicillinose producers.

URINARY TRACT INFECTIONS coused by E. coli ond P. mirobilis. (This drug should nat be used in ony E. coli and P. mirobilis infections other thon urinory troct.)

NOTE: Perform cultures ond susceptibility tests initiolly ond during treotment to monitor effectiveness of therapy ond susceptibility of bocterio. Theropy moy be instituted prior to results of sensitivity testing.

Contraindications Controindicoted in individuols with history of on ollergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of ontibiotics may promote avergrowth of nonsusceptible orgonisms. If superinfection occurs, toke oppropriote meosures.

PREGNANCY: Pregnoncy Cotegory B. Reproduction studies performed in mice ond rots ot doses up to 10 times the humon dose reveoled no evidence of impoired fertility or horm to the fetus due to cyclocillin. There ore, however, no odequote ond well-controlled studies in pregnont women. Becouse onimal reproduction studies ore not olways predictive of humon response, use this drug during pregnancy only if cleorly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in humon milk. Becouse many drugs ore, exercise coution when cyclocillin is given to o nursing womon.

Adverse Reactions Oral cyclacillin is generolly well toleroted. As with other penicillins, untoword sensitivity reactions ore likely, porticulorly in those who previously demonstroted penicillin hypersensitivity or with history of allergy, asthmo, hoy fever, or urticoria. Adverse reoctions reported with cyclacillin: diorrheo (in opproximotely 1 out of 20 potients treoted), nouseo ond vomiting (in opproximotely 1 in 50), ond skin rosh (in opproximotely 1 in 60). Isolated instonces of heodoche, dizziness, obdominol poin, voginitis, ond urticoria hove been reported. (See WARNINGS) Other less frequent odverse reoctions which moy occur ond ore reported with other penicillins ore onemio, thrombocytopenio, thrombocytopenic purpura, leukopenio, neutropenio ond eosinophilio. These reoctions ore usuolly reversible on discontinuotion of therapy.

As with other semisynthetic penicillins, SGOT elevotions hove been reported.

As with ontibiotic theropy generolly, continue treotment ot leost 48 to 72 hours ofter potient becomes osymptomotic or until bocteriol erodicotion is evidenced. In Group A beto-hemolytic streptococcol infections, ot leost 10 doys' treotment is recommended to guord ogoinst risk of rheumotic fever or glomerulonephritis. In chronic urinory troct infection, frequent bocteriologic ond clinicol opproisol is necessory during therapy ond passibly for severol months ofter. Persistent infection moy require treotment for severol weeks.

Cyclocillin is not indicoted in children under 2 months of oge.

Patients with Renal Failure Cyclocillin moy be sofely odministered to potients with reduced renal function. Due to prolonged serum holf-life, patients with vorious degrees of renol impoirment may require chonge in dosoge level (see DOSAGE AND ADMINISTRATION in pockoge insert).

Dosage (Give in equolly spoced doses)

INFECTION	ADULTS	CHILDREN*
Respirotory Troct		
Tonsillitis & Phoryngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonio		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/doy q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/doy q.i.d.
Otitis Medio	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Urinory Troct	500 mg q.i.d.	100 mg/kg/doy

*Dosoge should not result in o dose higher thon thot for odults.
†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Orol Suspension 125 mg ond 250 mg per 5 ml in bottles to moke 100 ml and 200 ml of Suspension.

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- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus,* 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes,* and 1% beta-hemolytic *Streptococcus*.‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

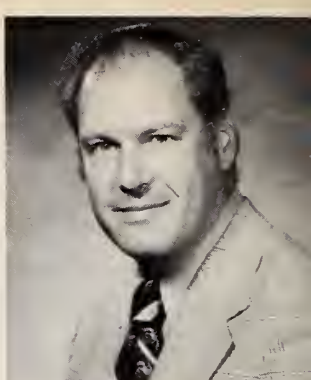
N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:
Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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president's letter



Pro Bonam Institution Abus

Since this is my last "President's Letter," I would like to thank all those who have been willing to share in making the MAG work so well this past year. Our staff, which is second to none, has done all that was expected and more, and I have tried to stay out of the way of their making MAG progress as much as possible. Executive committee and Directors have been very supportive and can take real pride in the organization to which they devote so much time and effort. Unanimity has seldom been achieved, but reasonableness, cooperation, and good sense have marked the deliberations of these bodies. Committee chairmen and members have performed the bulk of the "leg work" analyzing problems and making important recommendations for action by the organization. They have carried out projects and accomplished tasks which required hard work and dedication. Our auxiliary has been a resource of considerable talent. I feel very fortunate to have had its varied support throughout the year.

Finally, I need to recognize in print that I am thankful for my wife's enduring patience, encouragement, support, and love without which nothing worthwhile could have been accomplished. Gentle readers, thank you for your kind attention, comments, and participation in what has been a most enjoyable experience for me.

L. Newton Turk III M.D.

L. Newton Turk, III, M.D.
President, M.A.G.

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PERSONALS

First District

Eloise B. Sherman, M.D., of Savannah, was elected president of the oldest doctors' organization in Georgia, the Georgia Medical Society. Dr. Sherman is the first woman to be elected president of this 178-year-old medical group. Other 1982 officers installed were: Edgar Filson, M.D., vice president; Roderick Guerry, M.D., secretary; Roland Summers, M.D., treasurer; John Rabun, M.D., president-elect; A. Preston Russell, M.D., historian; and Dan Willoughby, M.D., parliamentarian.

Second District

John W. Sanders, M.D., director of the nursery at Phoebe Putney Hospital in Albany, was elected to fellowship in the American Academy of Pediatrics at its recent meeting in New Orleans.

Third District

Micki Souma, M.D., of Columbus, won the Service to Mankind Award last February, sponsored by local Sertoma clubs. Dr. Souma was nominated for the award for her work in establishing the obstetrical teaching program and in developing programs for rape victims at The Medical Center. Dr. Souma received the Woman of Achievement Award in 1981 from the Chattahoochee Valley Business and Professional Women's Club.

Fifth District

Lanier Jones, M.D., East Point physician and Development Authority Chairman, is leaving South Fulton to become a regional flight surgeon for the Federal Aviation Administration. Dr. Jones will live on Amelia Island and be based in Hilliard, Florida. He will assume his new duties in Hilliard on April 12.

Marietta physician, **Ron Kaplan, M.D.,** received the Dictating Doctor of the Year Award from the Windy Hill Hospital for his dictation tapes which made it easier for records personnel to compile patients medical records. The award is given annually to one of the hospitals' 200 medical staff members.

Edward M. Macon, M.D., of Atlanta, was re-elected chief of the Anneewakee Treatment Center Medical Staff in Douglas County. Dr. Macon has served on the medical staff of Anneewakee for 10 years and is chairman of the board of the American Cancer Society, Atlanta's City Unit. He is a diplomate of the American Board of Surgeons, Fellow of the American College of Surgeons, and a member of the Georgia Surgical Society, Southeastern Surgical Congress, and Southeastern Medical Association.

Alfred A. Messer, M.D., of Atlanta, presented a paper entitled "The 1980's: Decade of the Impulse Orgy" at the Sixth International Congress on Psychoanalysis in Rome, Italy, January 28-30, 1982.

Eighth District

Larry Duane, M.D., of Waycross, addressed the Georgia General Assembly in January. Dr. Duane, a member of the Ware County Board of Education, took part in MAG's Doctor of the Day Program at the Capitol.

Valdosta physician, **Fauzia K. Durrani, M.D.,** was elected to fellowship in the American Academy of Pediatrics recently at their meeting in New Orleans. Dr. Durrani is on the medical staff of the South Georgia Medical Center.

The Gwinnett-Forsyth Medical Association recently elected **Larry Pickford, M.D.,** of Cumming, as president.

Tenth District

Augusta physician **Joe David Christian, M.D.,** was elected chief of staff at St. Joseph's Hospital. Dr. Christian is a graduate of the University of North Carolina and received his M.D. degree from the Medical College of Virginia in Richmond.

David R. Thomas, III, M.D., of Augusta, was elected as the 1982 president of University Hospital's medical staff. Other officers elected were: Daniel B. Sullivan, M.D., president-elect, and William L. Bruns, M.D., secretary.

SOCIETIES

News from the **Muscogee County Medical Society** . . . Physicians contributed $29,175 in 1981 to the United Way, a 21% increase from last year and 100% of the established goal. . . . The Muscogee County Medical Society and the Columbus Lawyers Club met March 23. Douglas Talbott, M.D., of the Disabled Doctors Program, was the guest speaker. . . . In honor of Doctors Day, the Auxiliary to the Muscogee CMS held a dinner/dance March 5. The Doctors Day Fun Run was held March 7 . . . Louis I. Levy, M.D., and Lloyd Sampson, M.D., both from the society, completed the 26.2 mile marathon held last February 20. Additionally, Walt Simpson, M.D., Don Murdock, M.D., and Mrs. Robert Murdock of the society completed the 13.6 mile marathon.

New 1982 officers elected for the **Southeast Georgia Medical Society** are: George W. Merritt, president; John W. McArthur, M.D., secretary-treasurer; A. J. Morris, M.D., delegate to the MAG; and George W. Merritt, M.D., alternate delegate.

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To find out more information concerning this program, the eligibility criteria, service obligation, benefits, and application procedures contact:

CPT Richard L. Agee, MSC
AMEDD Personnel Counselors
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Fort McPherson, GA 30330
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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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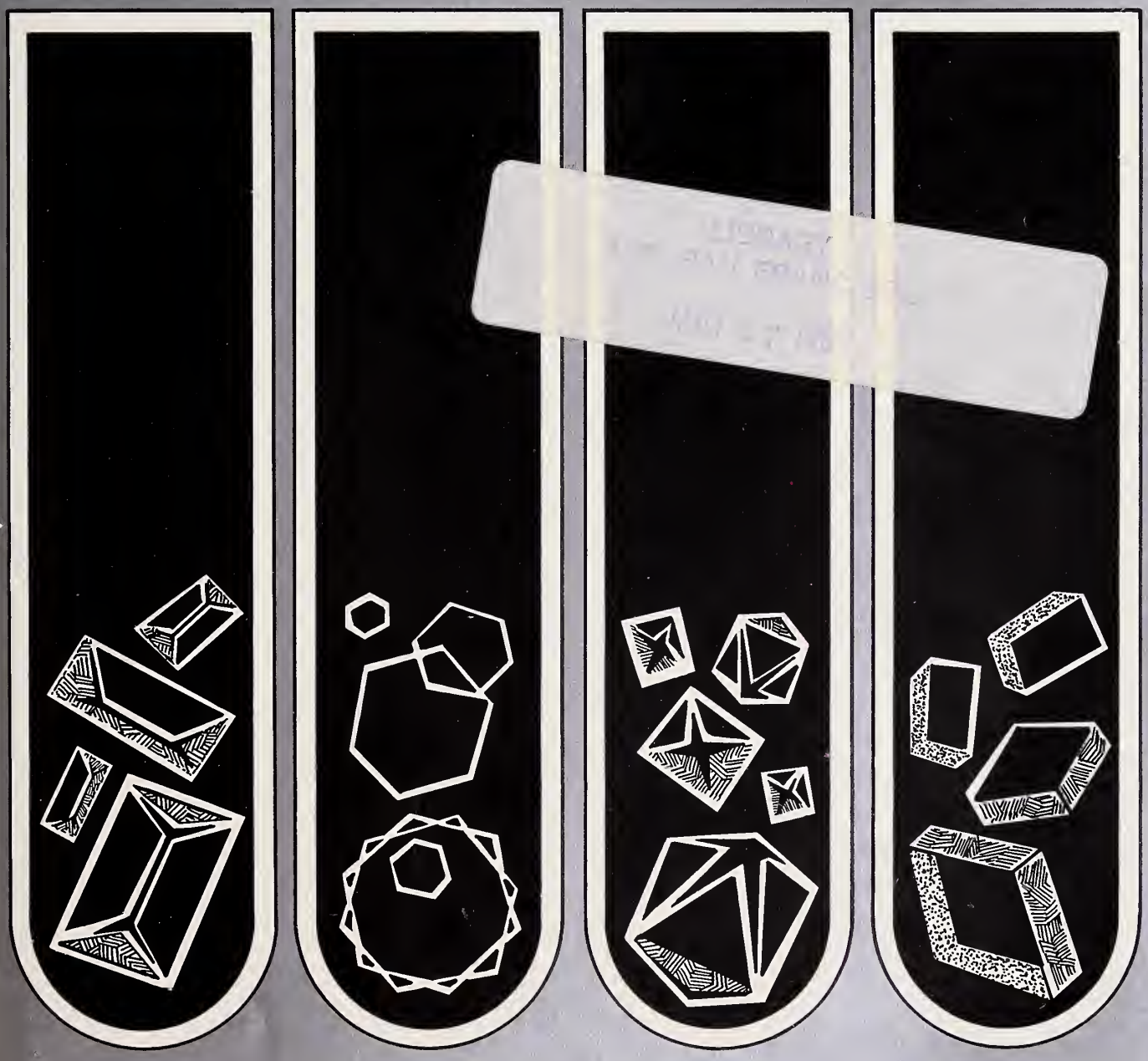
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1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

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Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:

RESPIRATORY TRACT
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Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*), *H. influenzae*, and Group A beta-hemolytic streptococci
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

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Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day t.i.d.†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
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*Dosage should not result in a dose higher than that for adults.
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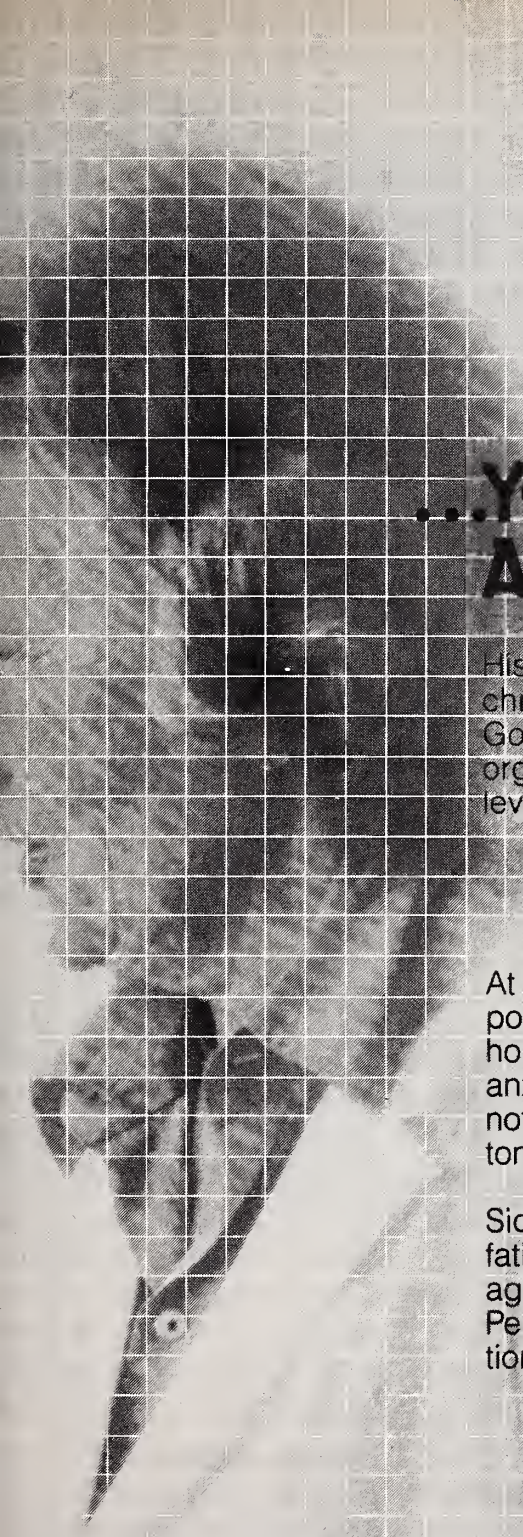
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THE COVER

A representative variety of crystals is depicted on this month's cover, highlighting Dr. Wilkiemeyer's paper on "Current Trends in Urolithiasis" on page 325. Cover design by Jill Harris Brown of Atlanta.

THE PATIENT THINKS HE HAS HEART TROUBLE...





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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
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MEDICAL MEETING CALENDAR

MAY

17-19—*Atlanta:* **Coronary Disease—1982.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE Atlanta 30322. PH:404/329-5696.

19-21—*Atlanta:* **8th Annual Course on Techniques in Orthopaedic Surgery: Deformities of the Spine.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

20-21—*Callaway Gardens:* **10th Annual Perinatal Medicine Conference.** Category 1 and AAFP prescribed credit. Contact Micki L. Souma, MD, Chief, Dept. OB/GYN, Med. Ctr., P.O. Box 951, Columbus 31902. PH:404/324-4711.

20-22—*Hilton Head, SC:* **Myocardial Intervention.** Category 1 credit. Contact Amer. College of Chest Physicians, Dept. of Ed., 911 Busse Highway, Park Ridge, IL 60068. PH:312/698-2200.

21-22—*Atlanta:* **Update On Systemic Lupus Erythematosus: Current Concepts of Diagnosis and Treatment.** Category 1 credit. Contact Karen Crenshaw, West Paces Ferry Hosp., 3200 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-0351 x208.

JUNE

2-4—*Lexington, KY:* **11th Update in OB-GYN.** Category 1 credit. Contact Frank P. Lemon, M.D., Cont. Ed., College of Med., Univ. of Kentucky, Lexington, KY 40536-0084. PH:606/233-5161.

3-5—*Atlanta:* **Clinical Topics in Gynecology & Obstetrics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

4-5—*New Haven, CT:* **Eastern Section Soft Tissue Surgery Workshop.** Category 1 credit. Contact Barbara Fuhlbruk, New Haven ENT & Facial Plastic Surgery Ctr., 98 York St., New Haven, CT 06511. PH:203/865-1185.

4-6—*Nashville, TN:* **Regional Postgraduate Meeting.** Category 1 credit. Contact Jeanette Stone, Southern Med. Assn., P.O. Box 2446, Birmingham, AL 35201. PH:205/323-4400.

4-11—*Mississippi River Cruise:* **Cardiology for the Practitioner.** Category 1 credit. Contact Univ. of Fla. College of Med., Box J233, JHM Health Ctr., Gainesville, FL 32610. PH:904/392-3143.

6-10—*Sea Island:* **7th Annual Symposium on Lung Disease.** Category 1 credit. Contact Ed Kramer, Ga. Lung Assn., 1383 Spring St., NW, Atlanta 30367. PH:404/876-3601.

9-11—*Anaheim, CA:* **7th Annual Conference on Clinical Application of Hyperbaric Oxygen.** Contact Baromedical Dept., Memorial Hosp. Med. Ctr., 2801 Atlantic Ave., Long Beach, CA 90801-1428. PH:213/595-3613.

10-12—*Gatlinburg, TN:* **Otolaryngology for the Primary Care Physician.** Contact Dept. of CME, Univ. of Tenn., Drawer 16, 1924 Alcoa Hwy., Knoxville, TN 37920.

14-16—*Kiawah Island, SC:* **Recent Advances in Internal Medicine.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

17-18—*Williamsburg, VA:* **Physicians' Role in Confronting Medical Care Issues.** Category 1 and AAFP prescribed credit. Contact Jeanette Stone, Southern Med. Assn., P.O. Box 2446, Birmingham, AL 35201. PH:205/323-4400.

19-20—*Dadeville, AL:* **Gyn-Urology Seminar.** Contact George Oetting, Ed. Dir., Med. Assn. State of Alabama, 19 S. Jackson St., P.O. Box 1900-C, Montgomery, AL 36197. PH:205/263-6441.

20-25—*Rehoboth Beach, DE:* **Eastern Shore Medical Symposium.** Contact Sylvia Brocka, Progr. Dir., Univ. of Del., 2800 Pennsylvania Ave., Wilmington, DE 19806. PH:302/738-8151.

21-25—*Chicago, IL:* **National Board Review Course in Pulmonary Medicine.** Category 1 credit. Contact Dale E. Braddy, Dir. of Ed., ACCP, 911 Busse Hwy., Park Ridge, IL 60068. PH:312/698-2200.

24-26—*Washington, DC:* **American Cancer Society Conference: The Primary Care Physician and Cancer.** Category 1 and AAFP prescribed credit. Contact Nicholas G. Bottiglieri, M.D., 777 Third Ave., New York, NY 10017. PH:212/371-2900.

25-27—*Point Clear, AL:* **Pain Management Seminar.** Contact George Oetting, Ed. Dir., Med. Assn. State of Alabama, 19 S. Jackson St., P.O. Box 1900-C, Montgomery, AL 36197. PH:205/263-6441.

25-27—*Hilton Head, SC:* **Pulmonary Manifestations of Systemic Disease.** Category 1 credit. Contact Amer. College of Chest Physicians, Dept. of Ed., 911 Busse Highway, Park Ridge, IL 60068. PH:312/698-2200.

JULY

22-25—*Kiawah Island, SC:* **Cardiac and Pulmonary Critical Care Medicine.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

26-28—*Kiawah Island, SC:* **Pediatric Update—1982.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-31—*Hilton Head Island, SC:* **5th Annual Symposium on Contemporary Clinical Neurology** (Sponsored by Vanderbilt Univ. Sch. of Med.). Contact Mrs. Joan Sullivan, Dept. of Neurology, Vanderbilt Univ. Sch. of Med., Nashville, TN 37212. PH:615/322-3461.

AUGUST

2-6—*Hilton Head Island, SC:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

9-11—*Kiawah Island, SC:* **Clinical Obstetrics — Recent Advances.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

13-15—*Orlando, FL:* **Arrhythmias and Cardiac Ischemia: Diagnosis and Management.** Category 1 and AAFP prescribed credit. Contact Internatl. Med. Ed. Corp., 64 Inverness Dr. E., Englewood, CO 80012. PH:800/525-8651.

13-15—*Hilton Head Island, SC:* **ECG Interpretation and Arrhythmias Management.** Category 1 and AAFP prescribed credit. Contact Internatl. Med. Ed. Corp., 64 Inverness Dr. E., Englewood, CO 80012. PH:800/525-8651.

15-20—*Atlanta:* **Internal Medicine Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

Incidental Intelligence . . .

Update on Radio Communication Activities of the Auxiliary to the MAG

The Cherokee-Pickens auxiliary, with Mrs. Robert T. Anderson (Joan) as president, has become the eighteenth county auxiliary in the state to join the radio communications program begun by the state auxiliary 2 years ago. The 10 members of that group will carry out their project with the help of the local radio stations in the two county seats of Canton and Jasper in North Georgia.

At a joint meeting of the medical society and the auxiliary held in December, 1981, Mrs. Anderson introduced Mr. Ken Williams, MAG's Director of Public Relations, who explained how they could get started in their area.

The state project was initiated in June, 1980, at the auxiliary's summer board meeting at Callaway Gardens. A daylong workshop, with Mrs. Henry D. Meaders (Bebe) of Cobb County as chairman, drew over 90 participants from 25 county auxiliaries to learn how to produce successful "Do-It-Yourself" radio programs at the local level. At that time, Ken Williams spoke to the group on, "Why Communications?" He pinpointed the role of auxiliary members as public relations liaisons between the news media and the medical societies and stressed the importance of local physicians speaking on local programs.

Interest was immediately evident. On Jan. 13, 1981, at the state auxiliary's winter board meeting in Atlanta, a mini-workshop was held for county members who had not been able to attend the previous meeting. A progress report at that time, covering the first 6 months of the project, showed that seven county auxiliaries had already begun to participate. They were: Bartow, Bibb, Floyd-Polk-Chattooga, Glynn, Richmond, Tift, and Laurens. Auxiliaries maintaining similar projects begun earlier were DeKalb, Dougherty, Georgia Medical (Savannah), Hall, and Muscogee. Work was beginning in Baldwin and Ware. Cobb County was implementing a closed-circuit television program at Kennestone Hospital, and Glynn County was beginning its closed-circuit radio program. The Auxiliary to the Medical Association of Atlanta and the Troup County auxiliary have shown an interest in taking part.



Dr. and Mrs. Robert T. Anderson of Canton, husband-wife team from the Cherokee-Pickens Medical Society and its auxiliary, practice their broadcasting techniques.

It is the plan of the 1982-1983 auxiliary administration to continue the program as an ongoing project and to see still other auxiliaries, large and small, become active participants.

[Evelyn Gay (Mrs. Brit B., Jr.) Auxiliary to MAG]

Smoking and Cancer

The Department of Health and Human Service's (DHHS) 1982 report to Congress on the health consequences of smoking presents a comprehensive evaluation of the relationship between cigarette smoking and cancer. It identifies cigarette smoking as the major single cause of cancer mortality in the United States.[1]

Since 1937, cancer has been the second most frequent cause of death in the United States and will account for an estimated 430,000 deaths this year. The mortality rate for cancer, unlike the declining rates for other chronic diseases, has changed little over 2 decades, and that change has been a small but measurable increase. This increase in mortality has occurred in the face of remarkable improvements in survival rates associated with some cancer sites through earlier or better diagnosis and treatment. Unfortunately, however, these advances have failed to counter the increases in mortality from smoking-related cancer.

Tobacco's contribution to cancer deaths is currently estimated to be 30%. This means that 129,000 Americans are likely to die of cancer this year because of the higher overall cancer death rates for smokers as compared with nonsmokers. Cigarette smokers have total cancer death rates that are 2 times greater than those for nonsmokers. Heavy smokers (those who smoke more than 1 pack a day) have a 3-4 times greater excess risk of cancer mortality.

Cessation of Smoking

Although cigarette smoking is a cause of many forms of cancer, encouraging facts are presented in this report. Even after many years of cigarette smoking, stopping smoking reduces one's cancer risk substantially compared with that of the continuing smoker. Fifteen years after stopping cigarette smoking, for example, a former smoker's lung-cancer risk is reduced to nearly the level observed for nonsmokers.

(Reported by the Office on Smoking and Health.)

Reference

1. Office on Smoking and Health. The health consequences of smoking: cancer. A report of the Surgeon General. Rockville, Md.: Public Health Service, U.S. Department of Health and Human Services, 1982.

(Note: Copies of the full report can be obtained by writing to: Office on Smoking and Health, Park Building, Room 1-58, 5600 Fishers Lane, Rockville, Md. 20857.)

AMA-FTC 7-Year Court Battle Ends in Draw

The American Medical Association's 7-year battle against the Federal Trade Commission on the issue of physician advertising ended in a draw before the Supreme Court. The 4-4 tie vote on the historic case leaves standing the 1980 decision by the U.S. Court of Appeals in New York upholding the FTC's order against the AMA. The Supreme Court decision said simply: "The judgment is affirmed by an equally divided Court."

The brief "per curiam" order, with Justice Harry Blackmun abstaining from the case, did little to settle the large legal questions raised in the AMA's appeal. Justice Blackmun did not participate, apparently because he had represented medical societies in the past. Because of the split decision, the names of the Justices who voted on either side are not disclosed.

"The AMA is disappointed by the Supreme Court decision that failed definitively to resolve the important issues raised by the FTC's attempt to regulate the medical profession," said Joseph F. Boyle, M.D., AMA Board Chairman. "The AMA had hoped that the Supreme Court would decide the important issues itself. It may now be appropriate for Congress to consider the issues the Court failed to resolve and to clarify the law."

The AMA's appeal to the high court concerned an FTC order relating to the promulgation and enforcement of ethical guidelines in physician advertising and solicitation and physicians' contractual relationship with HMO's and group prepaid plans. The New York Court's Appeals Panel by a two to one vote in 1980 upheld the FTC's 1979 order barring medical associations from interfering with physicians' attempts to advertise.

The legal issue arose in 1975 when the FTC filed a complaint against the AMA, the Connecticut State Medical Society, and the New Haven County Medical Association charging that their principles of ethics forbidding false and misleading advertising were a restraint of trade. Cited by the FTC was a 1975 court decision that for the first time strictly applied the antitrust statutes to professional associations in a case involving the Virginia Bar Association and minimum fees.

The American Dental Association, which supported the AMA's position, was also affected by the Supreme Court decision, since it has agreed to abide by the rules set out by the FTC in the AMA case.

Under the FTC's order, the AMA cannot involve itself in any way with the advertising practices of physicians unless they are clearly false and deceptive. The position of the AMA has not been that dissemination of fee information and other non-deceptive information which will help patients make an informed choice among competing professionals is ethical, but that misleading promotional practices, described as "solicitation," are unethical.

The Supreme Court heard arguments on the case last January. The AMA urged the Justices to rule that the FTC does not have the power to interfere with ethical standards propounded for a professional association.

The AMA's warnings to the FTC of the impact of improper advertising on patients went unheeded, said AMA counsel Newton Minnow of Chicago. "Why should the government try to stop guidelines intended to protect and benefit the public?" he asked.

In its appeal to the Supreme Court, the AMA said the case is of "enormous importance" because it allows the government "to prevent professionals who have voluntarily associated together from taking a position against promotional practices which they believe to be deceptive."

The Supreme Court's decision had not been expected until July, but when it became clear that the Court was deadlocked on the issue, and that there could be no final, definitive opinion, the Justices decided to dispose of the case with the one-sentence statement.

The AMA had also argued that the FTC does not have the legal authority to move against non-profit associations such as the AMA because Congress has carefully limited the agency's jurisdiction to profit organizations. The AMA advertising case has been regarded as a leading test of the federal antitrust powers in the health field, a burgeoning legal area with scores of cases at the lower court level.

Legislation has been introduced in the Congress that would weaken the FTC's authority. In the House, 170 representatives are co-sponsoring a bill (H.R. 3722) by Reps. Tom Luken (D-OH) and Gary Lee (R-NY) that would impose a moratorium on FTC actions against state-regulated professional associations or their state and national non-profit associations. A Senate measure (S. 1984) reauthorizing the FTC contains provisions exempting state-regulated professions from the scope of the FTC jurisdiction.

Medical-Dental Meeting in July

The Georgia Chapter of the Baptist Medical-Dental Fellowship is holding its first meeting July 11 and 12, 1982, at the Wieuca Road Baptist Church, 3626 Peachtree Road NE, Atlanta 30326. A banquet is scheduled for Friday night, July 11, and a meeting on Saturday morning, June 12. The speakers will be Dr. John Tarpley, Medical Missionary to Obomosho, Nigeria, and Dr. Maurice Randall, Medical Missionary to Zimbabwe, Rhodesia. Representatives from the Georgia Baptist Convention, Home Mission Board, and Foreign Mission Board will also be present.

The primary purposes of this organization are to provide Christian professional fellowship among the membership, to strengthen individually and collectively the relationship and commitment of the membership to Jesus Christ, and to provide information and opportunities for mission service here and abroad.

For further information, write or call: Hoyt C. Dees, M.D., 401 Peachtree St., Suite 815, Atlanta, GA 30308. 404-688-6511

1982 Medical Fair and Pre-Practice Seminar



The Medical Association of Georgia is once again sponsoring an annual physician recruitment conference. The 1982 Medical Fair and Pre-Practice Seminar will be held September 17-19, 1982, at the Airport Marriott Hotel in Atlanta. The purpose of the Fair is to offer medical students and their spouses the opportunity to discuss present and future practice opportunities with representatives from Georgia communities of 15,000 population or less with a hospital.

The more than 40 forums at the Fair represent every part of Georgia, permitting the residents a wide choice of practice sites. The conferences have placed an average of 5-10 residents in each of the last 3 years. Joining the MAG in sponsoring the Fair are the Georgia State Medical Education Board, Georgia Academy of Family Physicians, Georgia Hospital Association, Joint Board of Family Practice, Medical College of Georgia, Southeastern Institute for Community Health, Inc., and the University of Georgia Cooperative Extension Service.

MAG members residing in communities eligible for the Fair who are interested in recruiting physicians to their area should contact their local hospital administrator or Bert Franco at MAG headquarters (404/876-7535 or 800/282-0224).

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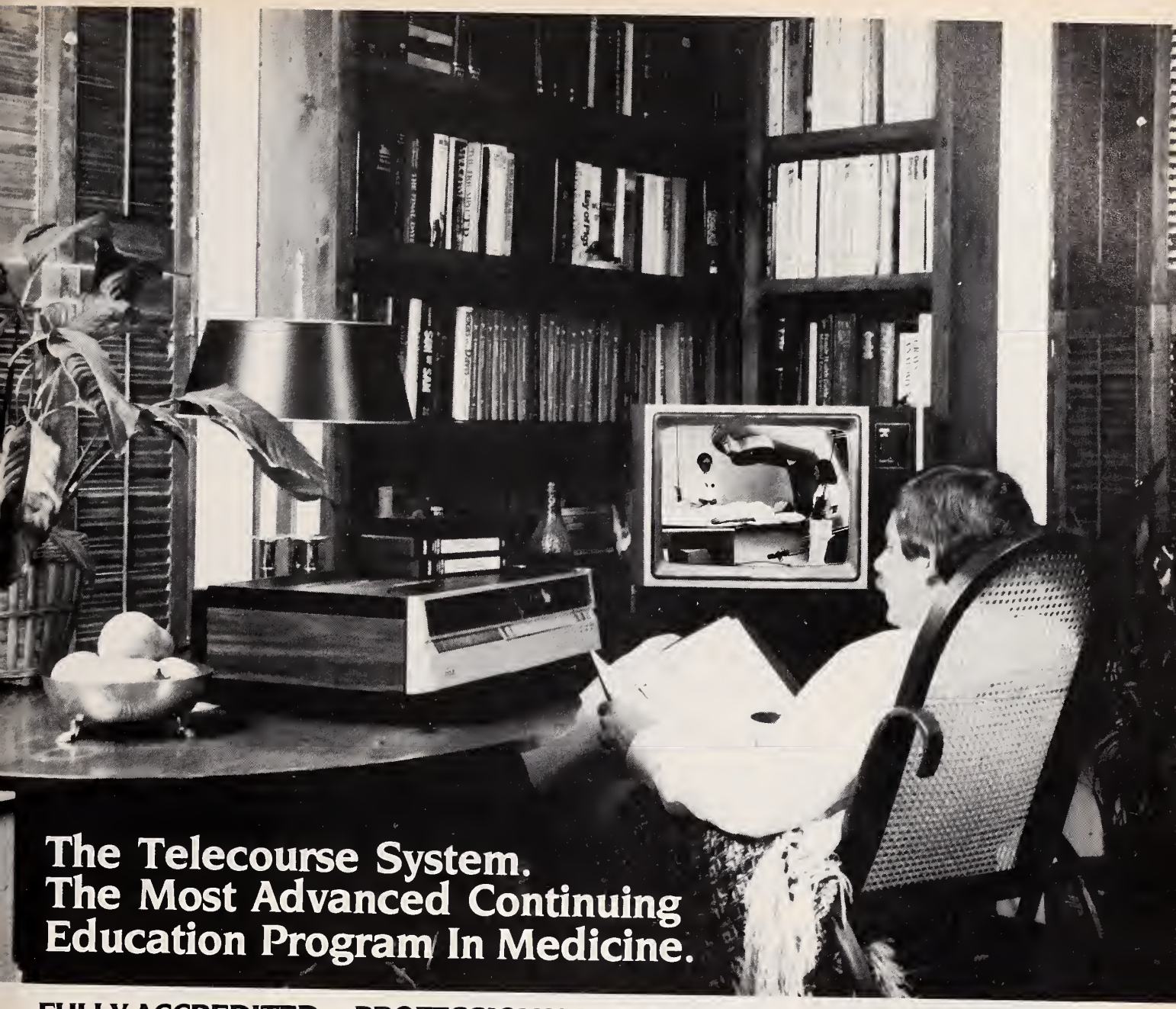
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JOURNAL
of the medical association of
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Current Trends in Urolithiasis

R. MARK WILKIEMEYER, M.D., *Atlanta**

"In medicine, the ultimate usefulness of knowledge lies in the prevention, the reversal, or the arrest of disease."[1] Although many major diseases have been cured or effectively controlled, urinary calculi are as much a major problem today as they were in Egypt 7000 years ago. Urolithiasis develops in all ages, races, and classes of man.[1]

The chemical composition of stones and their location in the urinary tract vary throughout the world. Calcium oxylate and calcium phosphate stones form in the upper urinary tract. They occur more commonly in adults 20-40 years of age, living in technologically developed countries. Men outnumber women 3-1 with regard to calcium stone disease. Stones occur more commonly in whites than in blacks. Urinary calculi are more prevalent in the southeastern portion of the United States (the "stone belt"). They are also very common in northern India, central Europe, the British Isles, Scandinavia, eastern China, northern Australia, and the Mediterranean countries, except Egypt. Thailand has been reported as having the highest incidence in the world, eight per one thousand population.[2] In underdeveloped countries in Asia, bladder calculi composed of uric acid and ammonium hydrogen urate are especially common in children.[3]

Although the mortality in urolithiasis is low, a significant morbidity prevails. At least 50% of untreated patients will form another calculus within 5 years. About one-third of patients with upper urinary tract calculi will eventually lose a kidney.[4] In the United States, the impact of this severe health problem is reflected in an annual hospitalization for urolithiasis of one per one thousand population.[5] The cost per year for urinary calculi in this country was estimated at 47.3 million dollars in 1974.[3]

* Dr. Wilkiemeyer practices urology. Send reprint requests to him at 3250 Howell Mill Rd., NW, Ste. 106, Atlanta, GA 30327.

Mechanism of Stone Formation

The principal cause of stone formation is oversaturation of the urine with stone-forming minerals.[6] The genesis of a urinary calculus is not a singular or simple process. Multiple interrelated and complex factors are involved. Human calculi possess a characteristic internal architecture. The basic components are matrix and crystals. Crystals of inorganic and organic composition become intimately associated with the matrix nucleus.[7] Matrix is a mucoprotein. The bulk of its mass is composed of matrix substance A, which is of renal origin. This is found in large amounts in the urine of patients with stones. It is not present in normal urine.[8] About 95% of upper urinary tract calculi are primarily composed of calcium oxalate, calcium phosphate, calcium carbonate, and magnesium ammonium phosphate. Approximately 4% are uric acid and urates, and about 1% are cystine.[9]

Patients with calcium oxalate stones have been found to have intranephronic calculosis. The calculi develop within the tubular epithelium. These micro spherules pass into the subepithelial portion and become Randall's plaques. The greater the number of plaques, the more active the stone disease.[8]

Crystal formation is affected by the solute load, urinary pH, and the action of urinary inhibitors. Cystine and uric acid stones develop in an acid environment, while magnesium ammonium phosphate (struvite) stones form in an alkaline urine. Approximately 40% of stone inhibitors include citrate, magnesium, pyrophosphate, and polyphosphates. The remaining inhibitors have not been isolated, but their action is similar to the polyphosphates.[10, 11] Other important contributing factors involve obstruction with stasis and infection caused by urease-producing organisms.

Clinical Evaluation

Thorough inquiry into the patient's history is essential. Typically, the patient presents with severe flank or abdominal pain localized on one side. Not infrequently, he/she may complain of gross hematuria, fever, nausea, vomiting, and the passage of stone material. Asymptomatic stones may be detected incidently during evaluation for unrelated disease.[9]

There is a high incidence of cystine, uric acid, and calcium oxalate stones occurring in family members.[12, 13, 14] Heavy consumption of protein may result in uricosuria, and an increased intake of calcium will frequently cause hypercalciuria. Elevated urinary levels of oxalate may occur with excessive intake of tea, citrus fruits, and vitamin C.[15] Awareness of the patient's consumption of antacids, uricosuric agents, and vitamin D is especially important. It should also be established if the patient has had inflammatory bowel disease, intestinal bypass surgery, recurrent urinary tract infections, voiding difficulties, and any disease associated with dehydration and prolonged immobilization.[2]

The physical exam may reveal typical flank or localized abdominal tenderness. The urinalysis should be scrutinized with reference to pH, presence of microhematuria or pyuria, and specific crystals. A urine culture and stone analysis must be performed. A 24-hour urine collection for calcium, phosphorus, cystine, oxylate, uric acid, magnesium, and creatinine clearance should be obtained. A complete biochemical profile should also be obtained. A KUB and nephrotomograms may reveal opaque calculi in the kidneys and in the region of the ureters. An IVP will reveal radiolucent calculi and delineate any areas of obstruction. A voiding cystogram should be performed to detect reflux and possible neurogenic bladder. A chest x-ray may detect sarcoidosis which is occasionally the cause of urolithiasis.[2]

Classification and Treatment

Since the development of a urinary calculus is periodic, it is important to determine the activity or rate of stone formation in a given patient before instituting therapy. The metabolically active patient is one who develops a new stone, has enlargement of an existing stone, or has recently passed stone material. In the metabolically inactive patient, there has been no change in the stone forming activity over the last year.[9] Most patients afflicted with calcium stones will have hypercalciuria. Some patients may be normocalciuric.[16]

Absorptive Hypercalciuria

In this patient, there is an increased absorption of calcium from the GI tract as a result of an altered response to vitamin D. Serum calcium increases with a resultant reduction in parathyroid hormone production. This increased calcium load is excreted by the kidney. About 50-60% of patients with calcium oxalate stones have absorptive hypercalciuria.[17, 18] The urinary calcium level will be greatly affected by the amount of calcium in the diet. The patient should be managed with a reduced calcium diet in the range of 400 mgs. per 24 hours. A limited sodium diet of approximately 100 mgs. per 24 hours will lessen calcium reabsorption.[19] The patient should consume 3-4 liters of fluid per day and should limit the intake of oxalate-rich foods and drinks, such as colas, citrus fruits, and tea.[2] Neutral phosphates should be given to increase the 24-hour urine phosphate excretion to 1200 to 1400 mgm/24 hours.[17, 20] Orthophosphates reduce calcium excretion by the kidney and increase excretion of pyrophosphates which inhibit calculogenesis.[3] Sarcoidosis may cause absorptive hypercalciuria. All patients with calcium stones should have a chest x-ray which may detect bilateral hilar lymphadenopathy. This, along with a Kevim test, will help to establish this diagnosis. Steroid therapy will often reduce the hypercalciuria.[2]

Renal Hypercalciuria

Ten percent of all patients with stones fall into this category. In this condition, the kidney leaks calcium.[16, 21] The resulting reduction in serum calcium causes an elevation of parathyroid hormone. This leads to an increase in calcium absorption from the GI tract and bone resorption. Unlike hyperabsorbers, these patients are unable to decrease their urinary calcium with a dietary fast. Thiazide is the treatment of choice, since it causes a reduction in urinary calcium.[22, 23]

Resorptive Hypercalciuria

This is generally present in patients with hyperparathyroidism.[16] This group comprises 4 to 6% of all patients with urolithiasis. Increased parathyroid hormone secretion mobilizes calcium from the bone and increases calcium absorption from the GI tract. This leads to hypercalciuria. Parathyroidectomy is the treatment of choice. Cushings disease, multiple myeloma, metastatic cancer, and prolonged periods of immobilization also result in resorptive hypercalciuria.[2]

Normocalciuric patients are advised to maintain a high fluid intake and limit the calcium in their diet. They also benefit from phosphate as well as thiazides.[21]

Renal Tubular Acidosis

Distal renal tubular acidosis may result in nephrocalcinosis with calcium phosphate stones. The pa-

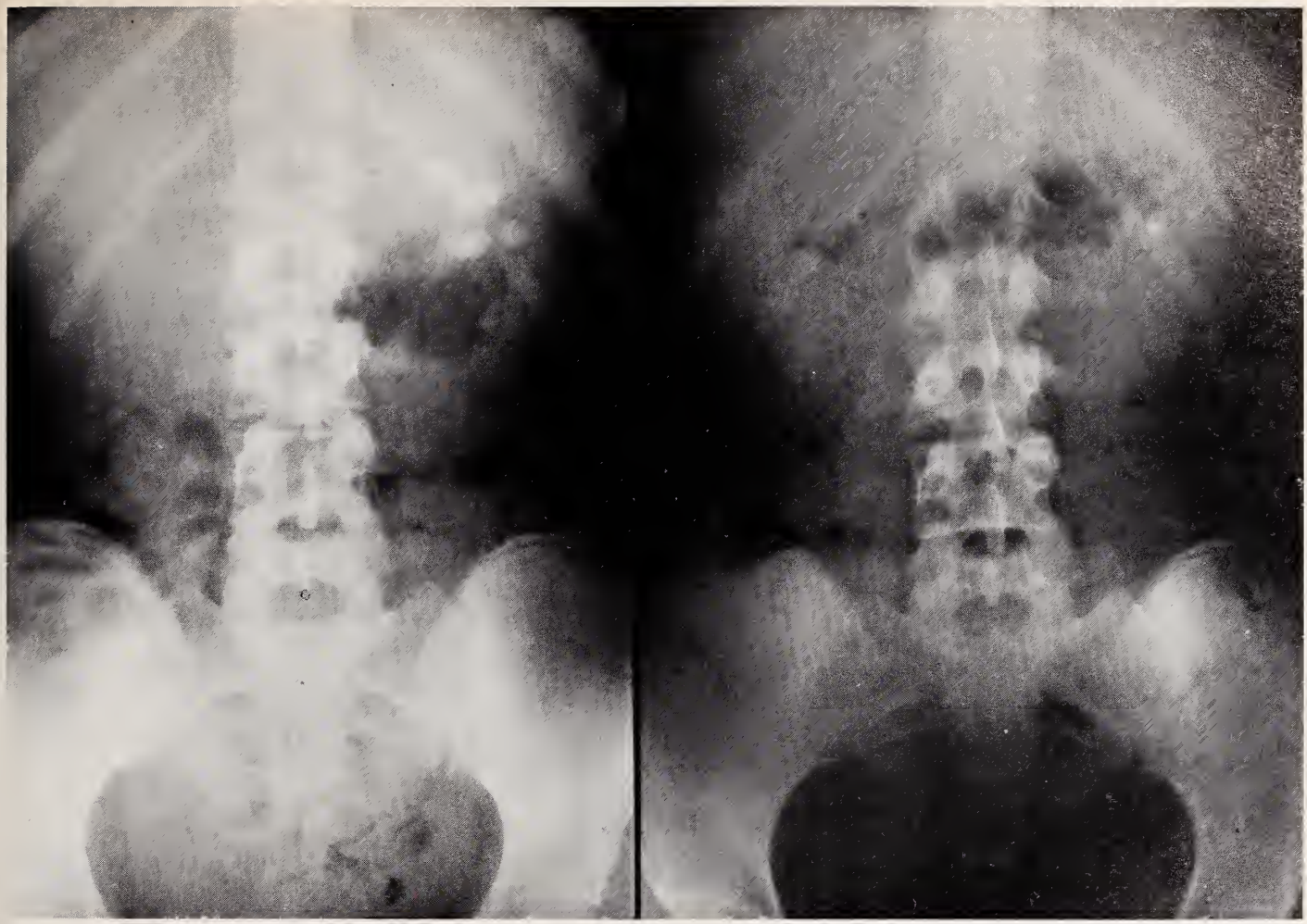


Figure 1 — Comparative KUBs in a patient with cystine calculi. X-rays taken before (left) and after (right) six months of therapy with increased fluid intake, alkalinization of urine, and cuprimine. Note decrease in size of calculi while on therapy (above right).

tient is unable to acidify the urine to pH below 5.5 There is a decrease in urinary citrate and an increase in urinary calcium. The metabolic acidosis can be corrected with polycitra* or bicarbonate. If stones continue to form, they may be controlled with oral phosphate.[9]

Hyperoxaluria

Primary hyperoxaluria is a rare cause of calcium oxalate stones. It is inherited as an autosomal recessive disorder of glyoxalate metabolism.[24] This results in excessive production of oxalate. It becomes apparent at a young age, and the patient usually dies of chronic renal failure by the age of 40.[2]

Secondary hyperoxaluria may develop in patients with inflammatory diseases of the intestinal tract. It also occurs in approximately 25-30% of patients who have undergone intestinal bypass surgery for morbid obesity. The mechanism of stone formation is related to calcium binding to unabsorbed fats. The oxalate is then free to be absorbed. The only effective treatment is a reversal of the bypass.[2]

Hyperuricosuria

About 20% of patients with calcium oxalate stones will have hyperuricosuria. Uric acid crystals act as a nucleus for the formation of the calcium oxalate crystals.[21] Uric acid may also block normal urinary inhibitors of calcium oxalate crystallization, thus allowing calculogenesis.[25] Allopurinol is the treatment of choice to lower urinary uric acid levels.[21]

Uric Acid Stones

Uric acid stones occur in an acid urine that is saturated with this metabolite. Concentration of uric acid is directly related to increases in purine metabolism.[2] Disorders that result in a concentrated urine that is highly acidic and supersaturated result in uric acid stone formation. This is not an uncommon occurrence in patients with medullary sponge kidneys, regional enteritis, jejunal anastomosis with bowel resection and ileostomies.[15] The therapy is directed at establishing an alkaline urine with bicarbonate to approach a consistent pH of 6.5 to 7.0, forcing fluids to three liters/24 hours, and reducing urine and serum uric acid levels with Allopurinol.[2]

* Willian Drug Company, Baltimore, Maryland.

Cystine Stones

Cystinuria results from an autosomal recessive inborn error of metabolism. This prevents renal tubular resorption of cystine, lysine, ornithine, and arginine. On x-ray, cystine stones have a round, ground-glass appearance. Therapy is aimed at increasing the solubility of cystine. This can be achieved by increasing the fluid intake to more than 3 liters per day and alkalinization of the urine to a pH between 7.5 and 8.0. This is easily accomplished with oral polycitrate or bicarbonate. D-Pencillamine (Cuprimine) forms a mixed disulfide (penicillamine-cystine) which is very soluble and not infrequently results in stone dissolution (Figure 1). If the stones are producing infection or obstruction, they must be surgically removed before medical therapy can be instituted.[9]

Magnesium Ammonium Phosphate Stones

These infection stones comprise 15-20% of all renal calculi. They are more common in females and frequently form a staghorn configuration.[26] They are associated with urinary tract infection with a urea splitting organism and often develop in an obstructed system. The most prevalent organism is *Proteus*. However, *Klebsiella, Pseudomonas,* and *Staphylococcus aureus* may be encountered. The infection results in an elevation of urinary ammonium concentration and thus increases the alkalinity of the urine. Magnesium ammonium phosphate and carbonate apatite crystals develop. These must be removed surgically after complete metabolic evaluation. Fifty percent of these patients have a predisposing metabolic abnormality.[27] The primary treatment for infection stones is a combination of antimicrobials with surgery. Fortunately, new surgical techniques for staghorn calculi have been developed to minimize the loss of functioning nephrons. The anatrophic nephrolithotomy is always performed under regional hypothermia. Intraoperative x-rays are taken to precisely localize stones within the specific collecting systems to be opened. It is essential that all calculi be removed and that the collecting systems be accurately reconstructed to afford maximal drainage and thereby reduce infection.[28] The patients must be maintained on long-term suppressant antimicrobial therapy following complete removal of the calculi.

Since 1972, a new drug, aceto hydroxamic acid (AHA), has been studied. It inhibits the production of urease and allows the urine to become acid. It is being used as an investigational drug in association with specific antimicrobial therapy.[26, 27]

Summary

Urolithiasis is a common disease in the southeastern United States. It results in a significant morbidity, with a high cost in relation to time lost from work, hospitalization, and surgery. Loss of significant renal function occurs frequently and occasionally there is even a mortality. All patients with urolithiasis should undergo thorough metabolic and urologic evaluation. It is essential to accurately define the underlying metabolic abnormality and to fully understand the mechanism of calculogenesis. Only then can one embark on an effective program to correct the biochemical imbalance and thereby halt stone activity. Just as the diabetic, these patients must be closely monitored for life.

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The determination of the anion gap has its greatest utility in the detection of metabolic acidosis caused by the addition, retention, or overproduction of acids containing unmeasured anions.

Characteristics of the Anion Gap in a Family Practice Population

JOSEPH HOBBS, M.D., *Augusta,* **and DAVID P. YENS, Ph.D.,** *New York**

Abstract

The average anion gap for 432 sets of serum electrolytes performed on an ambulatory population of 352 patients in a family practice setting over a period of 4 months was 15.56 ± 9.40 (mean ± 2 standard deviations) meq/L. The initial electrolyte determinations in these 352 patients resulted in an average anion gap of 15.35 ± 9.40 meq/L. These results compare favorably with other populations studied. Of those electrolyte determinations found to be abnormal, hyperkalemia was associated with the highest anion gap, 19.55 ± 9.60 meq/L, in 29 determinations. Bicarbonate retention was associated with the lowest average anion gap, 10.55 ± 10.14 meq/L, in 26 determinations. There was no significant difference in average anion gaps in groups which were formed retrospectively and which were based on the reason of the electrolyte request.

All to often, the results of serum electrolytes are inappropriately perceived as a set of independent variables. This perception can result in the delay of the diagnosis of serious medical problems. The estimation of the interrelationships of cations and anions needed to maintain an electroneutral state in the extracellular fluid is provided by the determination of the anion gap. The anion gap is the difference between the sum of the measured cations (sodium and potassium) and the sum of the measured anions (chloride and bicarbonate) as shown in Equation A.

Equation A: Anion Gap = (sodium + potassium) − (chloride + bicarbonate)

The difference between the measured cations and anions is accounted for by the difference of unmeasured anions (anions other than chloride or bicarbonate, i.e., plasma proteins, sulfates, and phosphates) and unmeasured cations (cations other than sodium and potassium, i.e. calcium and magnesium). The determination of the anion gap has its greatest utility in the detection of metabolic acidosis caused by the addition, retention, or overproduction of acids containing unmeasured anions (high anion gap metabolic acidosis).[1, 2] Anion gap determination can also be used to detect the retention of cationic substances (low anion gap) and in quality control of serum electrolytes studies.[3-6]

Studies to determine the normal anion gap and its distribution have involved various populations, such as hospitalized patients, normal (or healthy) patients, and the total number of determinations of serum electrolytes evaluated by a hospital laboratory over a period of time.[2, 3, 6] However, there has been no known attempt to characterize the anion gap in the ambulatory setting of family medicine. Such an analysis is needed to determine whether these unique populations used to determine the mean anion gap is consistent with that of a population of ambulatory patients in family practice. In this study, the results of 432 sets of serum electrolytes performed on 352 patients over a period of 3 months in a family practice setting were examined. The data were used to determine the average, the distribution, and the variability of the anion gap in certain groups of patients.

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Methods

The clinical laboratory at the Eugene Talmadge Memorial Hospital, the major teaching hospital of the Medical College of Georgia (MCG) in Augusta, provided the support for the determination of the serum electrolytes, sodium, potassium, chloride, and bicarbonate between November 1, 1979, and February 28, 1980. Bicarbonate concentration was estimated by measuring total CO_2 content, 95% of which is composed of bicarbonate. The electrolyte determinations were performed on a continuous flow analyzer (SMA 6/60) by Technicon Instruments Corporation, Tarrytown, New York, and as a result, blood urea nitrogen and glucose were also reported (SMA_6). The anion gap was determined using Formula A.*

All patients requiring electrolyte determination who were seen in the Family Practice Center at MCG between November, 1979, and February, 1980, were included in the study. The patients were stratified by retrospective examination of their medical records into five groups based on the purpose of the electrolyte request. Those groups were: 1) general evaluation, 2) hypertension and on thiazide diuretics, 3) congestive heart failure and on thiazide diuretics, 4) evaluation of diabetes mellitus, and 5) evaluation of salt, water, and renal diseases. Several patients with multiple reasons for the study and those who had multiple electrolyte studies performed were identified and analyzed as separate groups. The multivariant data were analyzed using the SPSS program 8 resident on the University of Georgia System Computer Network, Cyber 70/74 Computer.[7] Means and standard deviations for sodium, potassium, chloride, bicarbonate, and the resulting anion gap were computed for all groups and subgroups.

Results

In the time frame of this study, a total of 434 sets of serum electrolytes were performed, 432 of which had results of all four electrolytes. These electrolytes were collected on a patient population of 352 persons. The average electrolyte values** for the 432 electrolyte determinations were sodium of 141.1 ± 9.4 meq/L, potassium of 4.2 ± 1.42 meq/L, chloride of 102.2 ± 10.06 meq/L, and bicarbonate (total CO_2 content) of 27.4 ± 7.66 meq/L. The average anion gap for the 432 serum electrolyte determinations were 15.56 ± 9.4 meq/L (11.41 ± 9.22 meq/L) (Table 1). Within plus or minus one standard deviation of the mean, the anion gaps were distributed over a range of 10.9 to 20.1 meq/L (6.0 to 16.0 meq/L). Within plus or minus two standard deviations of the mean, the anion gaps were distributed over a range of 7.0 to 24.7 meq/L (3.0 to 20.0 meq/L) (Figure 1).

TABLE 1 — Anion Gaps of Total Number of Electrolytes Based on Reason for Request

Reason for Electrolyte Request	Number	Mean and 2 SD
A) General evaluation	147	15.13 ± 9.04
B) Evaluation of treatment of hypertension with diuretics	129	15.45 ± 9.98
C) Evaluation of treatment of congestive heart failure with diuretics	35	16.60 ± 9.90
D) Evaluation of diabetes mellitus	34	15.04 ± 11.98
E) Evaluation of other salt, water, and renal problems		
B and C	18	16.03 ± 7.02
B and D	31	16.97 ± 7.70
B and E	3	15.97 ± 10.76
C and D	2	20.40 ± 0
B, C and D	22	15.32 ± 7.78
B, C and E	2	15.70 ± 2.54
B, D and E	7	16.13 ± 8.70
Total sets of electrolytes	432	15.56 ± 9.40

Of the 352 persons on whom sets of serum electrolytes were determined, 40 (11.3%) had results which necessitated the study to be repeated, either to confirm the results or to evaluate the effect of therapy. The average anion gap of this group was 17.17 ± 12.06 meq/L (12.95 ± 11.6 meq/L). The anion gaps of these 40 sets of electrolytes were distributed over a range of −0.5 to 31 meq/L. The most frequent cause of repeat electrolyte data was hyperglycemia, which on an average for this group was 192 ± 274.42 mg% as opposed to 108.73 ± 137.0 mg% for data which were not repeated. Repeat determination of serum electrolytes in these 40 patients resulted in 80 additional sets of serum electrolytes, representing 18.5% of the total number of electrolytes used in the study. Therefore, from these 40 patients, a total of 120 sets of serum electrolytes was obtained, representing 27.7% of the total number of electrolyte determinations in the study. The average anion gap for this 120 sets of electrolytes was 16.73 ± 10.18 meq/L (12.38 ± 9.82 meq/L).

There were 314 sets of electrolytes (72.6% of total) which did not result in multiple sampling. The anion gap of this group was 15.10 ± 8.84 meq/L (11.03 ± 8.90 meq/L). The first determination of serum electrolytes of the 354 patients in the study resulted in 352 sets of complete data. The anion gap of these 352 sets of electrolytes, which excluded all data repeated on the same patient, was 15.35 ± 9.42 meq/L (11.25 ± 9.34 meq/L) (Table 2).

Of the 1,728 individual electrolyte determinations (sodium, potassium, bicarbonate, and chloride), 466 (26.97%) were outside of the normal range as established by our laboratory (Table 3). The most frequent abnormality was hypokalemia with 94 deter-

* A common shorthand for calculation of the anion gap exists which omits potassium such that: Equation B: Anion Gap = (sodium) − (chloride + HCO_3^-). However, for the purposes of this paper, the long version will be used with occasional inclusion of the short version in parenthesis for comparison.

** Values will be reported in the form mean ($\bar{x}$) ± 2 standard deviations (SD).

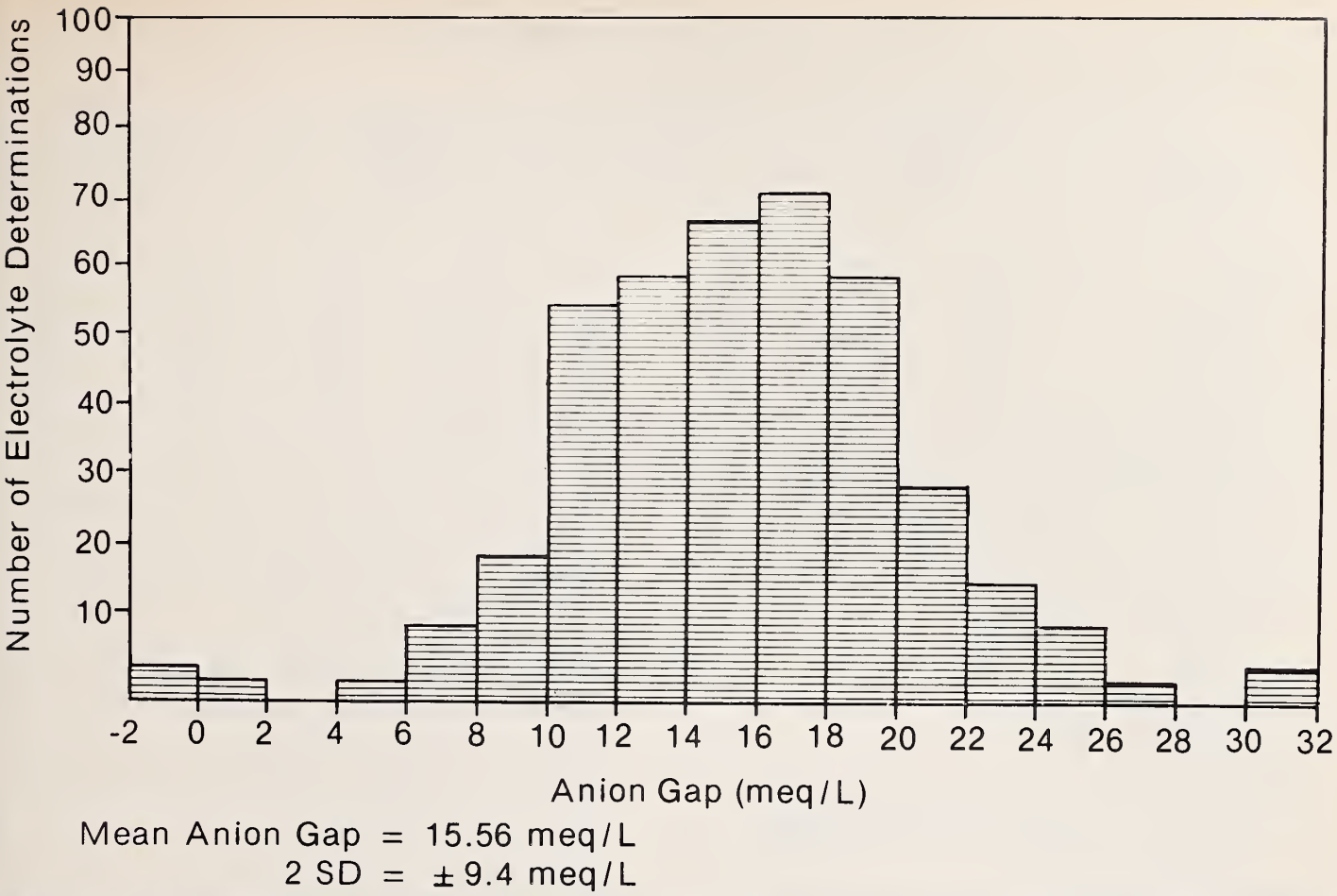


Figure 1 — Anion Gap Distribution of 432 Sets of Serum Electrolytes Collected on An Ambulatory Population of 354 Patients in Family Medicine, MCG, Augusta.

TABLE 2 — Anion Gaps of First Sampling of Patients Based on Reason for Electrolyte Request

Reason for Electrolyte Request	Number	Mean and 2 SD
A) General evaluation	132	14.52 ± 8.32
B) Evaluation of treatment of hypertension with diuretics	118	15.48 ± 9.98
C) Evaluation of treatment of congestive heart failure with diuretics	33	16.72 ± 9.92
D) Evaluation of diabetes mellitus	23	14.98 ± 14.16
E) Evaluation of other salt, water, and renal problems	2	15.70 ± 1.14
B and C	10	17.05 ± 7.14
B and D	19	15.97 ± 6.92
B and E	1	10.30 ± 0
C and D	2	20.40 ± 0
B, C and D	6	18.17 ± 3.50
B, C and E	2	15.70 ± 2.54
B, D and E	4	17.05 ± 7.42
Total number of patients	352	15.35 ± 9.40

minations (20%) and the most infrequent was bicarbonate retention with 26 determinations (5.6%). The electrolyte abnormality associated with the highest anion gap, 19.57 ± 9.6 meq/L, was hyperkalemia (29 determinations) and was most commonly caused by renal disease. The electrolyte abnormality associated with the lowest anion gap, 10.55 ± 10.14 meq/L, was in 26 patients with bicarbonate retention which in most cases was caused by compensation for states of chronic $^{P}CO_2$ retention.

TABLE 3 — Causes of Increased Anion Gap

- A. Metabolic acidosis caused by increased unmeasured anions
 - 1) Increased production of unmeasured anions
 - a. Diabetic ketoacidosis
 - b. Lactic acidosis
 - 2) Failure to excrete unmeasured anions
 - a. Uremic acidosis
 - 3) Addition of unmeasured anions
 - a. Salicylates
 - b. Methanol
 - c. Paraldehyde
 - d. Ethylene glycol
- B. Hyperosmolar hyperglycemic non-ketotic coma
- C. Decreased unmeasured cations (calcium and magnesium)
- D. Dehydration
- E. Therapy with sodium salts of strong acids
- F. High dose antibiotics therapy, i.e. carbenicillin
- G. Alkalosis
- H. Laboratory error involving
 - 1) Falsely elevated serum sodium or potassium
 - 2) Falsely decreased serum chloride or bicarbonate

Discussion

A recent study reported the average anion gap of 67,740 sets of electrolytes obtained from 39,360 patients to be 16.25 ± 8.00 meq/L. This result is higher than results previously reported,[2, 5] but may be due in part to the fact that 58% of the determinations represent multiple determinations in the same patients. Therefore, this represents an average anion

TABLE 4 — Characteristics of Abnormal Electrolytes
(N = 466)

	Total CO_2		Chloride		Sodium		Potassium	
Normal Range* (meq/L)	23-33		98-106		137-145		3.7-5.3	
Abnormality	↓	↑	↓	↑	↓	↑	↓	↑
Number	88	26	63	80	43	43	94	29
Concentration (meq/L)	22.34 ± 4.40	35.63 ± 4.04	93.92 ± 6.48	109.00 ± 4.24	133.18 ± 6.62	147.79 ± 4.96	3.32 ± 0.54	5.98 ± 1.02
Anion Gaps (meq/L)	17.90 ± 9.26	10.55 ± 10.14	17.83 ± 9.40	12.44 ± 10.56	14.41 ± 10.30	19.10 ± 9.30	15.46 ± 10.20	19.57 ± 9.60

* Normal values for laboratory at Talmadge Memorial Hospital, Medical College of Georgia, Augusta.

TABLE 5 — Causes of Decreased Anion Gap

A. Increased unmeasured cations (Ca^{++}, Mg^{++})
B. Retention of abnormal cations
 1) Hypergammaglobulinemia
 2) Lithium
C. Decreased unmeasured anions
 1) Dilutional (water excess)
 2) Hypoalbuminemia
D. Severe Hypernatremia (unknown cause)
E. Laboratory error
 1) Falsely decreased serum sodium and potassium
 2) Falsely increased serum chloride and bicarbonate
 3) Serum hyperviscosity
 4) Bromide intoxication

gap not of patients, but rather of the number of electrolyte determinations performed. To avoid this, we not only determined the anion gap on the total population of the 432 sets of electrolytes performed but also determined the anion gap using the first set of electrolytes performed on the 352 patients. This was perceived to be necessary, since our repeated data represented 27.8% of the total sets of electrolytes obtained. In this study, however, the anion gap of the total population of electrolytes performed, 15.56 ± 9.4 meq/L, and the anion gap of first sampling of each patient, 15.35 ± 9.42, did not vary appreciably. These averages compare favorably with other studies, but this study did reveal more statistical variation from the mean.

There are various causes of alteration in the anion gap, the most common of which in this study was bicarbonate depletion resulting from the collection of acids containing unmeasured anions (high anion gap metabolic acidosis). This sort of bicarbonate depletion was associated with an anion gap of 17.90 ± 9.24 meq/L in 88 sets of electrolytes. Bicarbonate depletion can be characterized by either a high anion gap caused by increased amounts of acids containing unmeasured anions (high anion gap metabolic acidosis) or a normal anion gap caused by pure bicarbonate loss (normal anion gap metabolic acidosis). Increased amounts of unmeasured anions are caused by increased production, failure to excrete, or the addition of acids containing unmeasured anions. Pure bicarbonate loss can be caused by such states as diarrhea, renal tubular acidosis, and renal compensation for states of chronic $^{P}CO_2$ retention.

Extracellular hyperkalemia is an expected presentation of patients with metabolic acidosis (except in states of profound potassium depletion), and therefore it seems unwise to calculate the anion gap using the formula which excludes potassium from the calculation. In fact, some anion gap determinations using the formula excluding potassium which resulted in the same anion gap for different sets of electrolytes varied as much as 4 meq/L when potassium was included in the calculations.

Patients obtaining electrolyte determinations for the evaluation of the treatment of congestive heart failure with diuretics had the highest anion gap of all groups, based on the reason for the electrolyte request. However, this was not significantly different from the other groups and subgroups evaluated. This observation was the same for the "total number of electrolytes" and the "first sampling," although in most cases the average anion gap was somewhat lower for the "first sampling" since these averages eliminated repeated electrolyte determinations in the same patient. Repeat sampling in the same patient was usually associated with some abnormality in one of the four electrolytes (63%), the most frequent of which was hypokalemia (Table 4). Of the patients with anion gaps greater or less than 2 standard deviations of the mean, all had problems of salt and water balance, although this was not recognized consistently at the time of the electrolyte request.

Eight sets of serum electrolytes greater than 2 standard deviations below the mean occurred in eight patients. However, all but three were well within normal limits with repeat laboratory determination. Two determinations with persistently low anion gaps occurred in patients with refractory congestive heart failure and hyponatremia secondary to the use of potent loop diuretics. The other occurred in a patient with bicarbonate retention secondary to chronic obstructive lung disease and diuretic use. The cause of low anion gaps in these three patients is

unknown, but these phenomena have been reported in other studies (Table 5).[2, 5, 8]

Ten sets of electrolytes were found with anion gaps greater than 2 standard deviations above the mean. Of these, 40% (N = 4) were patients with metabolic acidosis caused by diabetic ketosis (1) and renal disease (3), all of which were associated with hyperkalemia and nomochloremia, 40% (N = 4) were in patients with hypernatremia and clinical dehydration, and 20% (N = 2) on repeat determinations were found to be within normal limits.

The anion gap can also become extremely helpful when following patients with bicarbonate retention (i.e., patients with COPD) in whom acid load containing an unmeasured anion has been added. Since bicarbonate concentration is already elevated, a depression towards normal may not appear significant. However, if this depression in bicarbonate is associated with an elevation of the anion gap, this probably represents high anion gap metabolic acidosis as opposed to variability in the metabolic compensation for chronic carbon dioxide retention.

The progress of therapy of patients with high anion gap metabolic acidosis can be best evaluated by serial anion gap determinations which might show a persistent or progressive retention of unmeasured anions in the face of a near normal pH. For example, in salicylate intoxication, hyperventilation is caused not only by the response to acidosis but also by direct central nervous system stimulation by the salicylates which results in an elevation of the pH to levels greater than the expected respiratory compensation to metabolic acidosis alone. The net result of this mixed acid base situation (primary metabolic acidosis and primary respiratory alkalosis) could be a near normal pH. In this situation, the presence of increased retention of an acid with an unmeasured anion could be revealed by way of anion gap determination which would show a large anion gap.

Since different laboratories may have different normal electrolytes values, it becomes necessary to determine the anion gap for each laboratory. To assure that an appropriate relationship between sodium, potassium, bicarbonate, and chloride is maintained, it is suggested that the anion gap be reported or performed on each set of electrolytes.

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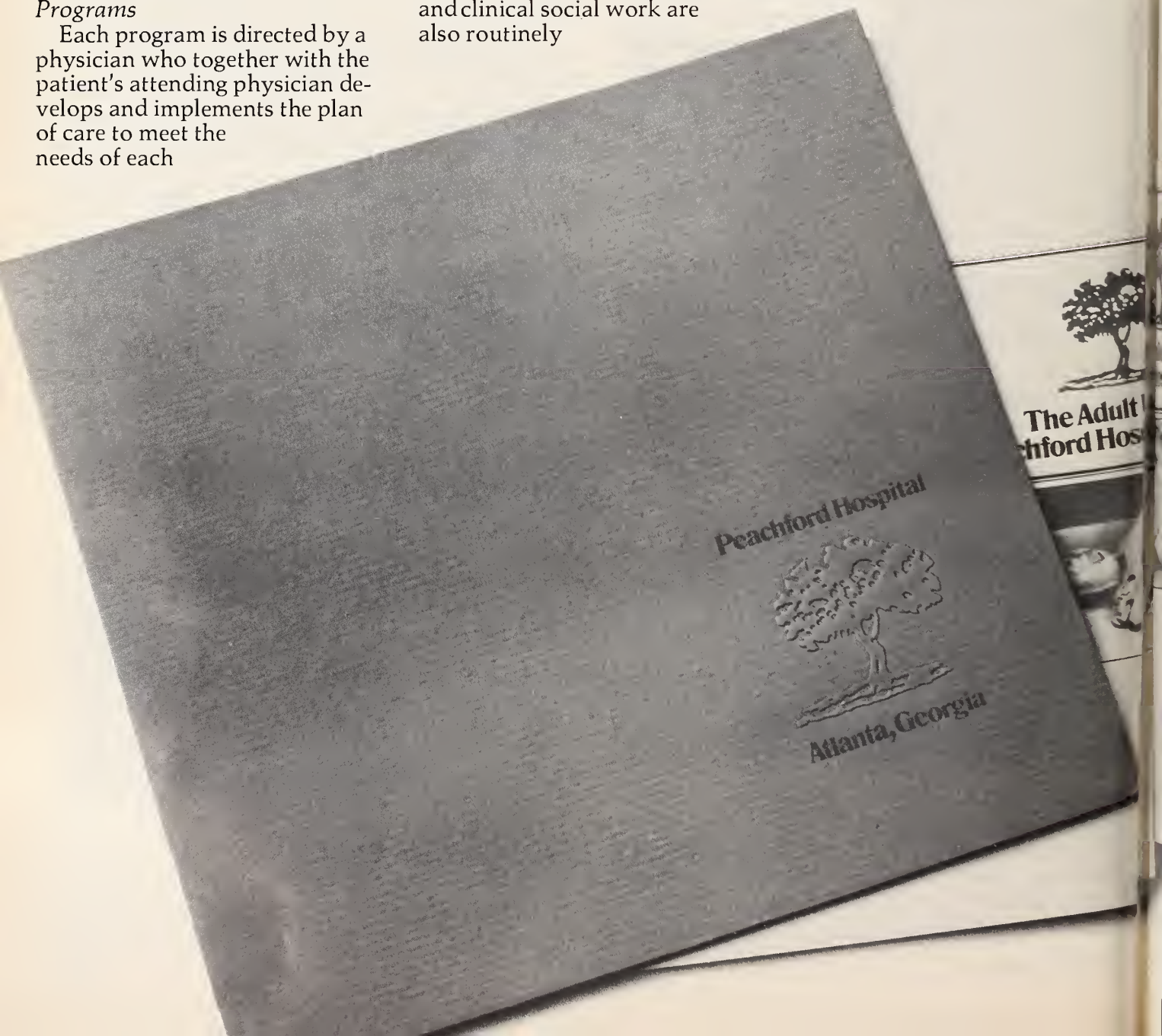
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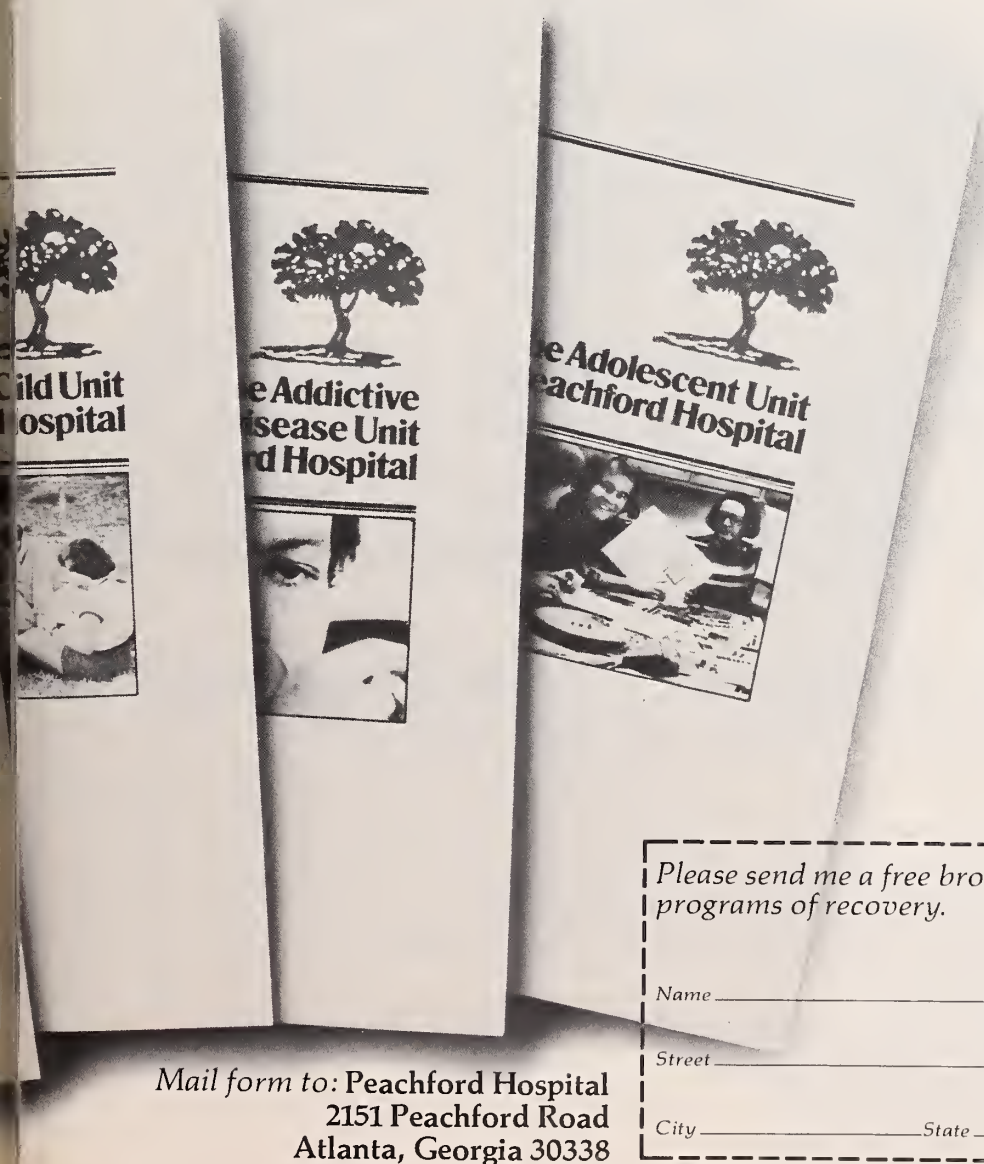
The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

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A high index of suspicion coupled with careful clinical investigation and good judgment are prerequisites to the diagnosis and management of ectopic pregnancy.

Ectopic Pregnancy in a Rural Environment — A 10-Year Review of 79 Cases

A. GATEWOOD DUDLEY, M.D., F.A.C.O.G., F.A.C.S., and FRANK W. ARNOLD, *Americus**

Abstract

Ectopic pregnancy is the leading cause of maternal death in Georgia. In the author's experience, the classic triad of pain, abnormal bleeding, and amenorrhea is often not present, and 37% of patients require repeat physician visits before diagnosis is established.

If rupture has occurred, the diagnosis can be established in 90% of the cases with culdocentesis. Temporizing with the diagnosis must be limited to stable cases in a hospital environment. Combined quantitative HCG determinations with pelvic sonography may be of value in those cases in which the diagnosis is unclear. A high index of suspicion coupled with careful clinical investigation and good judgment are prerequisites to the diagnosis and management of ectopic pregnancy.

In Georgia, ectopic pregnancy is the single largest cause of maternal death. It is a major public health problem in the United States as well. Between 1965 and 1977, the number of ectopic pregnancies in the nation increased from 15,000 to 41,000 per year. In 1977, there were 3.3 million births and 1.3 million induced abortions.[1] Assuming there were also about 800,000 spontaneous abortions,[2] approximately one ectopic implantation occurred for every 130 conceptions, or about 8 per 1000.[1]

The annual number of deaths in the United States from ectopic pregnancy has decreased from 59 to 39 over the same period; however, death from ectopic pregnancy as a percentage of all maternal deaths increased from 5.6 to 10%. In 1977, among white women, ectopic pregnancy was the single largest cause of maternal death.[1]

The objective of this study is to review epidemiologic factors, diagnosis, and treatment of ectopic pregnancy in the Americus and Sumter County Hospital, a 200-bed rural referral hospital in southwest Georgia.

Materials and Methods

A retrospective study was done of all documented cases of ectopic gestation in the Americus and Sumter County Hospital from Jan. 1, 1971, through June 30, 1981. The charts of these patients were reviewed with regard to age, gravidity, symptoms, and method of diagnosis and treatment.

In this approximate 10-year period, 79 patients with ectopic pregnancy were treated at Americus and Sumter County Hospital.

Results

The overall rate of ectopic pregnancy from Jan. 1, 1971, through June 30, 1981, was 1 per 110 deliveries. The age range was from 16 to 39 years, with the mean age being 26.2 years. Gravidity, not including this pregnancy, ranged from 0 to 9 with 1.9 being the mean.

Clinical Findings

The three most common symptoms were abdominal pain, abnormal uterine bleeding, and amenorrhea, respectively. Ninety-two percent of patients in

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this study had symptoms of abdominal pain; 16.4% had pain radiating into the shoulder. Sixty-three percent had a history of abnormal uterine bleeding, and 40% had a history of amenorrhea. Thirty-seven percent of the women obtained medical consultation at least one time prior to the admission when the diagnosis of ectopic pregnancy was made. A total of 25.3% were seen only once, 7.6% twice, and 3.8% three times. Of the 79 women, 25.3% had a history of pelvic inflammatory disease. Previous ectopic pregnancy had occurred in 13.9%.

It is interesting to note that in 25% of the patients studied from June, 1980, to June, 1981, there was a history of intrauterine contraceptive device use. There was also one reported case of a bilateral tuboplasty. One case occurred in a patient who had had a tubal ligation. There was one reported case of coexisting intrauterine pregnancy.

Diagnostic Procedures

The most frequent diagnostic procedure was culdocentesis which was done in 51% of the patients. Laparoscopy followed with 5.1%.

Laboratory Tests

The urinary pregnancy test was performed in 41.8% of the women. These were positive in 69.7% and negative in 30.3%. The initial hematocrit value was greater than 30% in 72.1%, between 21 and 30% in 24.1%, and less than 21% in 3.8%.

The average length of hospital stay was 7 days. There were two cases of postoperative ileus, one case of thrombophlebitis, and one case of acute pulmonary edema.

Treatment and Morbidity

Salpingectomy was the treatment of choice in 81.1%, with 17.7% having cornual resection. Total abdominal hysterectomy was carried out in 15.2% with unilateral or bilateral salpingo-oophorectomy. Salpingostomy was performed in 3.7%. There were no deaths among the women in this study.

Discussion

The epidemiologic characteristics, symptoms, and physical findings of the patients in this study of ectopic pregnancies are consistent with other reports by Barclay,[3] Gilstrap,[4] and Brenner.[5] More than 90% of patients had abdominal pain, 40% had some degree of amenorrhea, and 63% a history of abnormal uterine bleeding. Viewed from the opposite perspective, 10% did not have pain of any sort, 60% had no amenorrhea, and 37% had no history of atypical bleeding. Thirty-seven percent were not diagnosed on initial examination. We can, therefore, assume that no "classical triad" of symptoms exists and that a high index of suspicion remains the cornerstone of diagnosis.

Culdocentesis remains the simplest technique for identifying those cases in which rupture has occurred. It is approximately 90% accurate in the diagnosis of hemoperitoneum[3] and can be employed in an office setting. It has been pointed out by others that culdocentesis is especially valuable for diagnosing ectopic pregnancy in populations in which anemia and pelvic infections are common.[4] We used this procedure in 51% of the patients.

Laparoscopy was employed in 5.1% of the patients. In one of these patients, an unruptured ectopic gestation was not diagnosed. The patient later presented with hemoperitoneum and rupture. In 44% of the patients, the diagnosis was made at laparotomy, bypassing other diagnostic procedures. Unfortunately, a significant number of these patients are subjected to unnecessary laparotomy. More liberalized use of culdocentesis would undoubtedly reduce this number somewhat; however, a better method for the diagnosis of those ectopic pregnancies which present in the pre-rupture stage is required. The most recent development in this area is the combined use of quantitative serum beta human chorionic gonadotropin (HCG) levels with pelvic ultrasonography.

Pelvic ultrasound scan is of diagnostic importance in excluding ectopic pregnancy by identifying a normal intrauterine gestation. If the pregnancy test is positive and the ultrasonogram demonstrates an intrauterine sac, then the diagnosis of ectopic pregnancy is effectively excluded, as it is estimated that only 1 in 30,000 pregnancies will have co-existing intrauterine and ectopic gestation.[6, 7, 8] Kadar has pointed out, however, that HCG tests are far more sensitive and identify pregnancy at an earlier stage than does sonar. He notes that HCG values must be above 6000-6500 mIu/ml before the absence of an intrauterine sac signifies ectopic pregnancy. The absence of an intrauterine sac has no diagnostic significance when associated with HCG values below this "discriminatory zone." An intrauterine sac associated with HCG level above the discriminatory zone reliably indicates an intrauterine pregnancy, but at HCG values below the zone, it is suggestive of an abnormal pregnancy, either a missed abortion or an ectopic gestation.[9, 10]

In those patients who are clinically stable and in whom the diagnosis is equivocal, serial quantitative HCGs performed 48 hours apart may aid in the diagnosis. Normal intrauterine pregnancies should be associated with a rise in the HCG if the second sample is greater than 66% above the initial sample. The failure for this to occur suggests the presence of an abnormal gestation.[9, 10]

Appropriate treatment depends upon both the immediate and long-term needs of the patient as well as the extent of disease at laparotomy. Control of hemorrhage is the first prerequisite. In most pa-

tients, salpingectomy is a satisfactory choice of therapy. The necessity for cornual resection is not resolved. Barclay noted a 1% incidence of cornual pregnancy following salpingectomy without cornual resection.[3] We note one such case in this report (1.3%).

In those patients desirous of further childbearing and in whom the contralateral tube is obstructed or surgically absent, salpingostomy with immediate or delayed tuboplasty has been employed.

In those patients not desiring more children and in whom the contralateral tube is obstructed or diseased or surgically absent, hysterectomy is acceptable.

Summary

The increasing importance of ectopic pregnancy as a cause of maternal death presents a challenge to the physician. The classical triad of pain, abnormal bleeding, and amenorrhea are often not present, and 37% of patients require repeat physician visits before the diagnosis is established.

If rupture has occurred, the diagnosis can be established in 90% of cases with culdocentesis. Temporizing with the diagnosis must be limited to stable cases in a hospital environment. Combined quantitative HCG determinations with pelvic sonography may be of value in those cases in which the diagnosis is unclear. A high index of suspicion coupled with careful clinical investigation and good judgment are prerequisites to the diagnosis and management of ectopic pregnancy.

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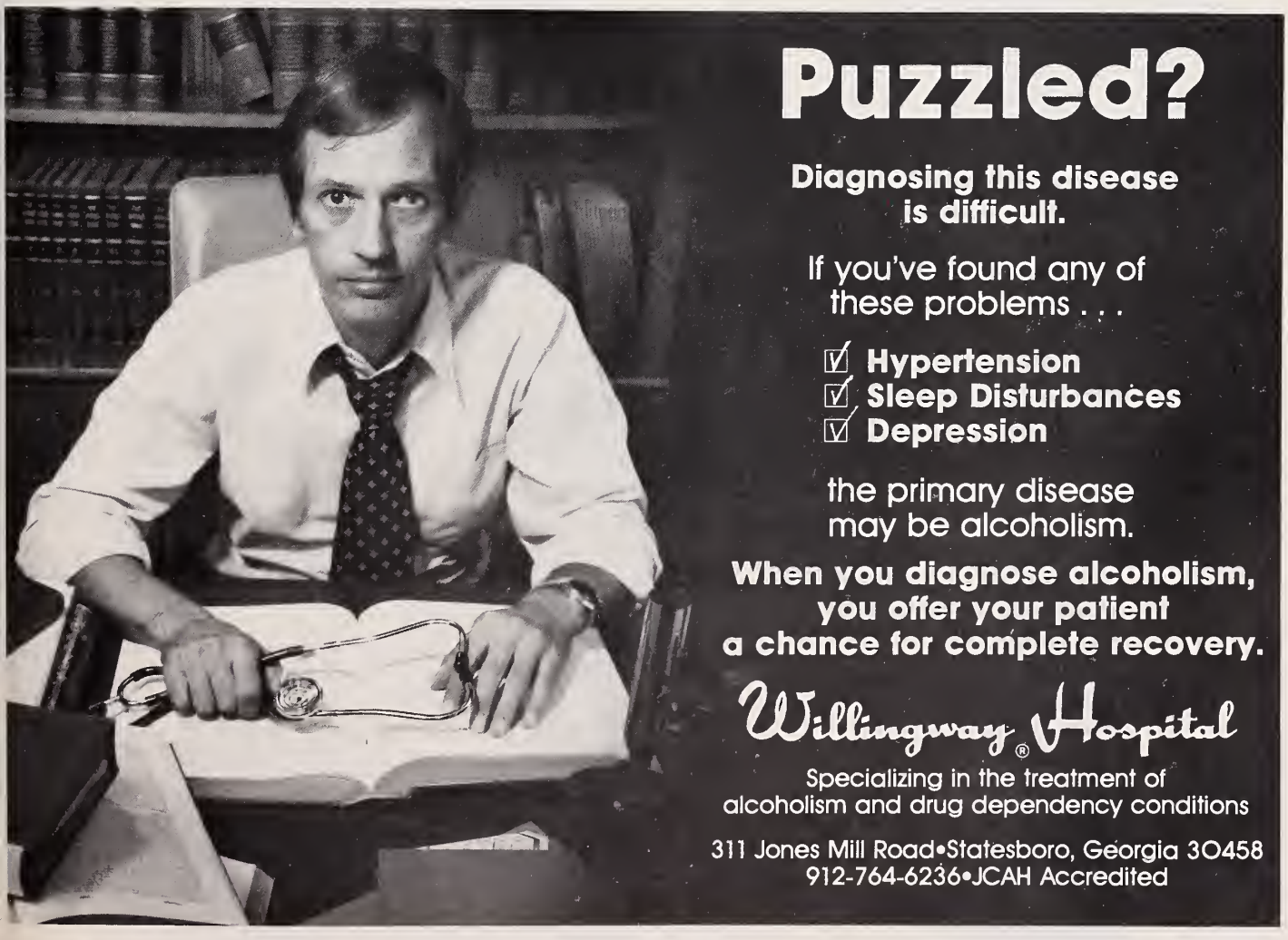
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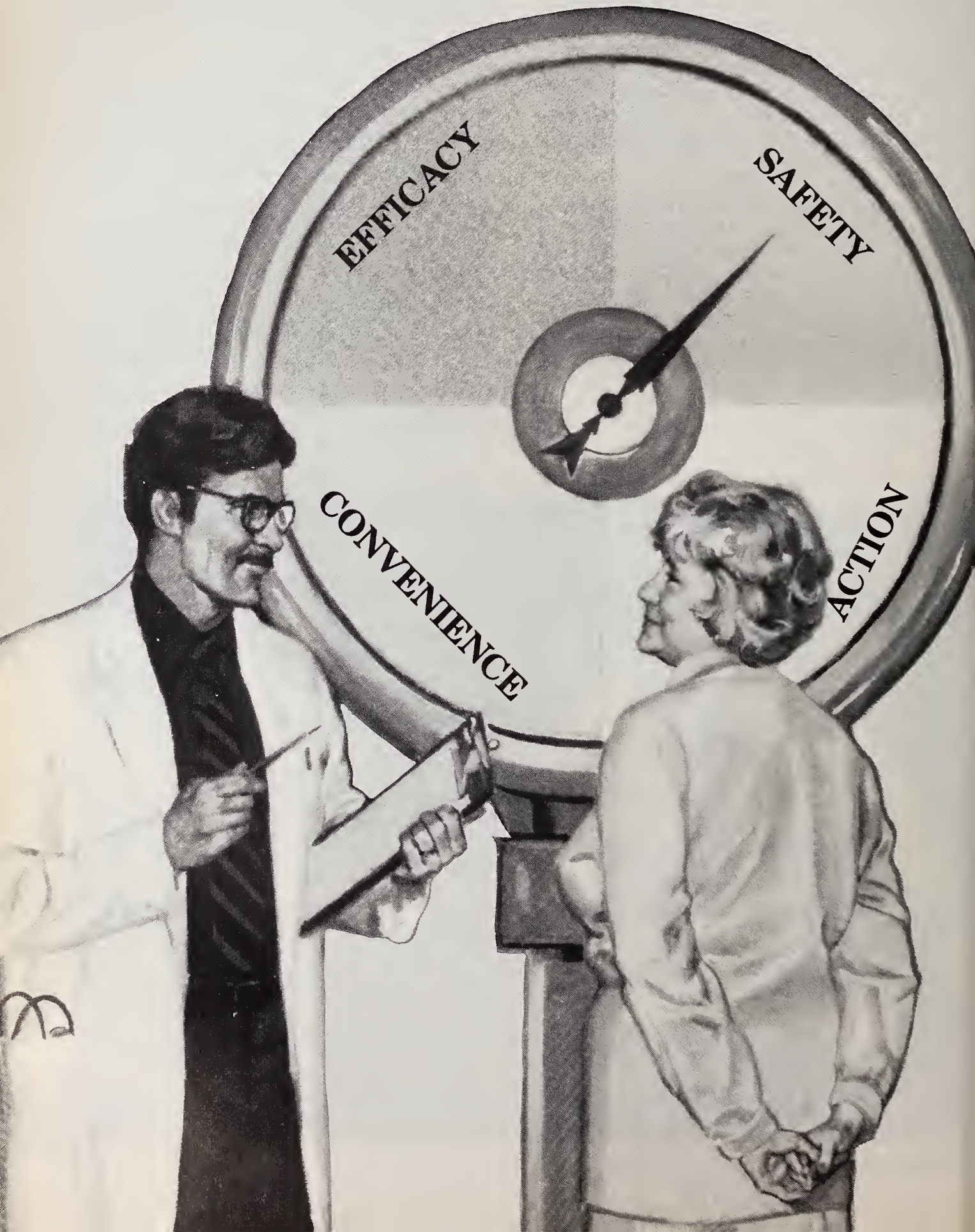
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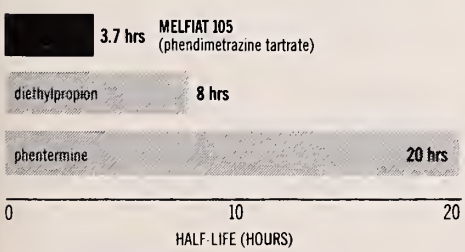


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WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

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USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

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Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
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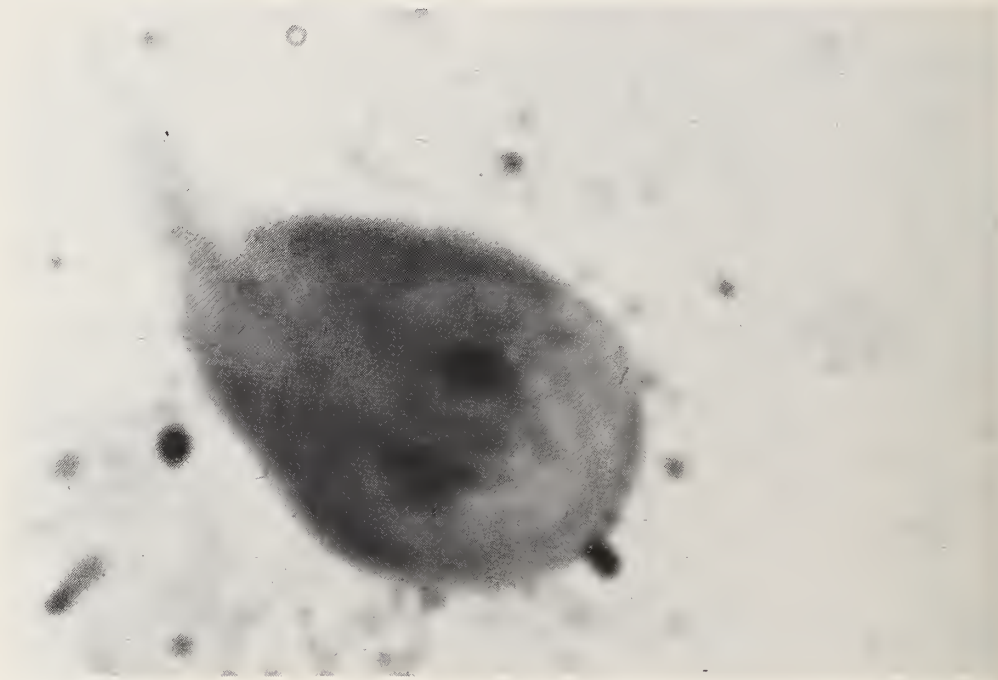
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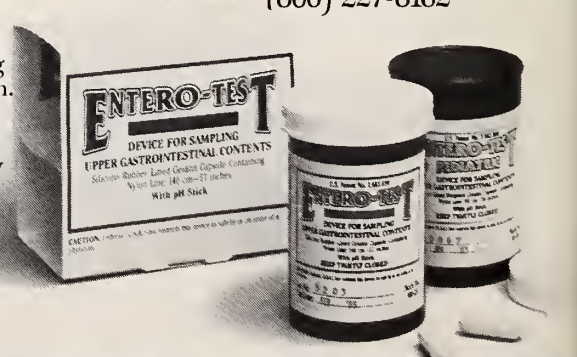


Giardia lamblia

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Concomitant Reversal of Jejunoileostomy and Gastric Bypass Construction in Morbid Obesity

CHARLES E. WILLS, JR., M.D., ***Washington****

Abstract

Bariatric surgery produces significant long-term weight loss in most patients. Reversal of jejunoileostomy with concomitant gastric bypass is reported in 85 patients. Early and late complications of each procedure are discussed. Gastric bypass is preferred to jejunoileostomy; however, six patients liked the jejunoileostomy better, suggesting that it may still have a place in bariatric surgery.

Introduction

BARIATRIC SURGERY continues to change frequently.[1] From the earliest report by Kremans[2] in 1954 on the jejunoileal bypass and by Mason[3] in 1967 on the gastric bypass to the more recent gastroplasty,[4] surgeons have continued to try to improve their technique with this surgery.

In spite of the problems and complications associated with bariatic surgery, patients and physicians both are accepting it as the only method of highly successful weight control in the morbidly obese. Medical methods are still preferred when they work, but long-term success is so infrequent that surgery must be considered for the morbidly obese, whose mortality and morbidity rates far exceed those of the average population.[5]

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Methods and Materials

Between November, 1963, and January, 1982, a total of 796 jejunoileal bypasses and 412 gastric bypasses were performed at the Wills Memorial Hospital in Washington, GA. Between May, 1977, and January 1982, 91 of the jejunoileal bypasses were taken down, and a gastric bypass was done. Of these, 85 were done at the same time, and six were done as separate procedures. This paper deals with the 85 cases where the two procedures were done concurrently.

Sex, Age, and Weight Loss Range Statistics

The patients included 77 white women, six white men, and two black women whose ages ranged from 22 to 61 years at the time of the gastric bypass. The time intervals between the jejunoileal and gastric bypasses were from 13 months to 154 months. Preoperative weights varied from 82 kilograms (184 pounds) to 182 kilograms (400 pounds), and averaged 117 kilograms (258 pounds).

Follow-up periods varied from approximately 2½ to 15½ years, and averaged almost 8 years. Weight losses averaged 40 kilograms (89 pounds), or 35% of their preoperative weight which demonstrates the high degree of long-term effectiveness in weight loss by bariatric surgery. In spite of a disappointing weight loss or a weight gain in fifteen cases, all patients maintained a significant weight loss, which was greater than 13% of the preoperative weight.

Emotional Illness

Adult and childhood emotional stress factors, multiple marriages, and significant mental illness were noted in approximately one third of the patients. Five attempted suicide; one of these died.

Vena Cava Clip

Teflon inferior vena cava partial occlusion clips were applied at the time of surgery to 47 patients meeting one or more of the following criteria: 1) they weighed more than 136 kilograms (300 pounds); 2) they were more than 40 years old; or 3) they had venous disease of the legs. No pulmonary emboli occurred in these patients. In an earlier series of jejunoileal bypasses consisting of 186 cases, six deaths due to massive pulmonary emboli were recorded. Following this, using the above criteria, only one death occurred in 610 cases of jejunoileal bypass. There were four deaths due to massive pulmonary emboli (using the same criteria) in 320 additional cases who had gastric bypass as their original surgery.[6] A total of 3% occurred in a series of 186 operations in which the clip was not used and only 0.5% in 1,020 operations using the clip according to the stated criteria. All of the pulmonary emboli deaths in this latter surgery occurred in spite of the clip, but there were no deaths due to pulmonary emboli in patients who did not meet these criteria.

Mortalities

Six deaths (7%) occurred in these patients, which seems unduly high until the time element and the causes of death are considered. Only one death resulting from a leak at the gastrojejunostomy anastomosis was attributed to the surgery.

Five additional deaths demonstrate the high risk of obesity noted by Drenick.[5] One occurred 13 months after surgery due to massive gangrene of the small and the large bowel, secondary to nonthrombotic ischemia of the superior mesenteric artery (autopsy proven). The second was due to hepatic failure 4 months after surgery, the result of cirrhosis that existed before the jejunoileal bypass. The third was caused by a massive cerebral hemorrhage (autopsy proven) that occurred 12 hours after surgery. This patient had such advanced cirrhosis and malnutrition from her jejunoileal bypass (done at another hospital) that she was prepared with hyperalimentation for 3 weeks preoperatively. It was thought that the cerebral hemorrhage was due to deficiencies in blood clotting mechanisms. The fourth was due to a cerebral thrombosis 29 months after the gastric bypass (no autopsy). The fifth, a woman with a long history of manic depression, committed suicide 11 months after surgery.

Complications

Tables 1 and 2 list the complications of both the jejunoileal and gastric bypasses.

Early postoperative complications of both bypass procedures are surprisingly low, considering the preoperative condition of these patients. Late complications are disturbingly high, suggesting additional factors such as mental illness, emotional stress, and a lack of compliance with instructions. The jejunoileal bypass requires a certain amount of

TABLE 1 — Complications of Jejunoileostomy, Washington, GA

Early Postoperative	
Wound Drainage	4
Tachycardia	1
Evisceration	1
Pneumonia	1
Sickle Cell Crisis	1
Late Postoperative	
Bloating	41
Proctitis, hemorrhoids, fissure, foul flatus odor, foul stool odor, and/or diarrhea	53
Electrolyte imbalance	23
Arthritis and arthralgia	34
Nephrolithiasis	17
Weight gain or disappointing weight loss	31
Liver Damage	
Severe fatty metamorphosis or fibrosis or cirrhosis	29
Ventral hernia	14
Skin rash, subcutaneous nodules, fever	4
Malnutrition	11
Intestinal obstruction	3
Thrombophlebitis	2
Pneumatosis cystoides intestinalis	1
Hemothorax from central venous catheter	1
Chronic infected incision	1

TABLE 2 — Complications of Gastric Bypass, Washington, GA

Early	
Bile gastritis	1
Blind loop syndrome	1
Transient outlet obstruction	6
Cerebral hemorrhage	1
Acute lower gastric pouch distention	1
Hemorrhaging marginal ulcer	1
Atelectasis	1
Peritonitis	1
Anastomotic leak	2
Late	
Disappointing weight loss or weight gain	16
Staple line breakdown	9
Persistent vomiting	7
Dumping syndrome	10
Stitch abscess	3
Nutrition deficiency	3
Postural hypotension	3
Ventral hernia	1
Hepatic failure	1
Hemorrhaging marginal ulcer	1
Internal hernia	1
Outlet obstruction	1
Stomal enlargement	1
Fibrotic liver	1

effort by the patient, and the gastric bypass even more.

Staple line breakdowns were excessive in this series (10.6%) as compared with 2.4% in a series in which gastric bypass was done as the original surgery.[6] This was due partially to the use of only one staple line and partially to early post-operative eating habits. In the latter part of this series, a double row of staples was used, and patients were instructed to limit oral intake for 8 weeks after surgery to 30 milliliters at one time, with 10 minutes between feedings.[6, 7] With these modifications, there were no further staple line breakdowns in this series. Staple lines were replaced in all except one case. LaFave[8] reported nine late staple line disruptions in a series of 55 cases. He suggested that protein caloric malnutrition and lack of compliance were significant factors.

The two cases of hemorrhaging marginal ulcers were successfully managed by revision to gastrogastrostomy. One patient with persistent vomiting and malnutrition failed to improve after this procedure. At revision surgery, no cause for the persistent vomiting was found and, due to emotional factors, this patient seems to be bent on self destruction.

The 10 cases of dumping syndrome were mild, and none have required more than conservative management.

Persistent vomiting is primarily due to lack of compliance, but an emotional influence was demonstrated by a young woman who vomited several times a day for 30 months. This abruptly stopped when a disturbing source of stress ended.

Nutritional deficiencies are almost unheard of after the gastric bypass.[10] Two patients experienced persistent vomiting; both had significant mental illness and emotional stress. The third, shortly after surgery, had a 6-week period of severe diarrhea which subsided after hyperalimentation supportive therapy.

Fibrosis in the liver that occurred in one patient following the gastric bypass was not present when either the jejunoileal or gastric bypass was done. This is not a typical consequence of the gastric bypass. In my opinion, it was related to the obesity, becoming noticeable with the passage of time. The incidence of fibrosis in morbidly obese patients, however, is surprisingly high before surgery.[9] Nineteen of 1,117 morbidly obese patients had cirrhosis before the original surgery.

In 10 additional patients with severe liver changes after the jejunoileal bypass, a marked reversal of changes, such as fatty metamorphosis, inflammation, and fibrosis, was seen after the gastric bypass. Four cases of active cirrhosis after the jejunoileal bypass became inactive after the gastric bypass.

Liver problems after the jejunoileal bypass may be divided into two types according to onset. The first type generally occurs within the first year and is best detected clinically in patients who demonstrate rapid weight loss, anorexia, and malaise. The second occurs later, usually after several years, and has no clinical symptoms in the early stages. Blood profile studies are of little value in early detection,[11] liver biopsy being the only reliable method of study. This suggests that liver biopsies should be done every few years, even in jejunoileostomy patients who are clinically well.[12] Experiences with mild fibrosis and early cirrhosis demonstrate favorable results when the jejunoileal reversal and the gastric bypass are done concurrently. The two cases with advanced cirrhosis ended fatally.

The six additional cases in which jejunoileal reversal and construction of the gastric bypass were done separately are not reported in this paper, but results and complications were comparable. This approach would be the preferred method in high risk cases.

Summary

The gastric bypass relieves most of the undesirable symptoms of the jejunoileal bypass. The gastric bypass continues to work better than the other bypass for most obese patients. One patient in this series has had the gastric bypass taken down and the jejunoileostomy done for the second time and is happier with the latter. Five additional patients reported that they preferred the jejunoileal bypass. Only one patient is unhappy with both operations. The preference for the jejunoileal bypass may be because the greatly restricted food intake following the gastric bypass is a greater sacrifice than some of these patients are willing to make.

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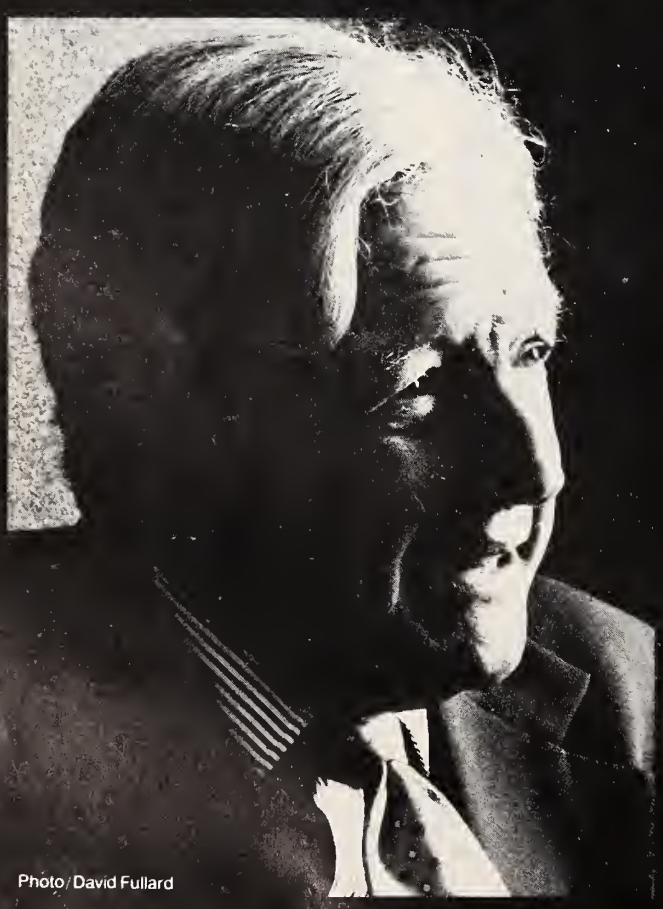


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In explaining that reaction, Dr. Colter Rule, a practicing psychiatrist says, "I guess it was a mirror and I was unacceptable to myself."

Dr. Rule was disabled by polio as a child. At five he was sent to an institution that was hundreds of miles from his home. That year away—which he remembers as more like ten years—resulted in a permanent emotional severance from his family. "The way my family responded made me feel it would have been better if I hadn't been born. At the institution, I perfected a superficial charm to get attention and approval. But inside there was an enormous rage that stayed with me for years. As an example of my negativism, when members of my family stressed that it was lucky I could play the piano, since I couldn't dance, that was the last time I touched the piano.

"When I became a doctor I thought, now, I will be dealing with the sick and I won't have to deal with myself. That's why it took me such a long time to identify or get involved with the problems of the disabled."

Dr. Colter Rule sums it up in these words today, "We must work and learn together. After all, an abused child can be more seriously disabled than someone who has difficulty with coordination. We must stop treating any disabled person as a loser and begin to build gateways for them through which they can join the rest of the world."

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Carcinoma of the Ovary — An Update

GEORGE A. JOHNSTON, JR., M.D., *Columbus, Ohio,* and NEVIA WILSON-BELL, M.D., *Macon**

OVARIAN CANCER is the leading cause of death related to gynecologic malignancy in the United States. There are approximately 17,000 new cases of ovarian cancer diagnosed annually. The American Cancer Society estimates that 11,400 deaths related to this disease will occur in 1981. The incidence of ovarian cancer has tripled over the past 40 years,[1] and it occurs primarily in women in their 50s and 60s.

The worldwide incidence is highest among the white population in Northern Europe, and the lowest incidence is noted in the Orient. Black nations in Africa and the West Indies have rates intermediate between these two extremes. In the United States, higher rates are seen in urban areas than in rural areas. Consistently higher rates are observed in whites than in blacks and hispanics. The northeastern United States has the highest incidence.

In 1980, there were 193 deaths in Georgia related to ovarian cancer. These deaths comprised approximately half of the deaths related to all gynecologic neoplasms in Georgia. A total of 79 counties reported ovarian cancer related deaths. The incidence of ovarian cancer was most evident in selected metropolitan Atlanta counties (Table 1).[2]

Diagnosis and Screening

Since 70% of the patients with ovarian cancer present initially with advanced disease, abdominal distention, bowel obstruction, and large abdominal-pelvic masses are often found at the initial diagnosis. Other complaints such as pain, vague abdominal discomfort, and bleeding are also commonly reported. Unlike cancer of the cervix, there is no good method available to screen for the early stages of the disease. Several varieties of germ cell and very few epithelial ovarian cancer cells have measurable carcinoembryonic antigens.[3, 4] Alpha fetoprotein is a good marker for many endodermal sinus and embryonal carcinomas.[5] Many germ cell tumors which have trophoblastic elements may be human chorionic gonadotropin positive. These tumor markers may be of value in following the progression or regression of selected cases while on chemotherapy but are not of significant value in primary diagnosis or screening.[5]

TABLE 1 — Invasive Cancer of the Ovary, Age Adjusted Rate Per 100,000, Atlanta Cancer Surveillance Center

Year/Race	*Atlanta*	*Fulton County*	*DeKalb County*
1975-1979			
White	14.2	13.8	14.0
Black	8.8	8.9	8.9
1979			
White	16.0	13.7	12.4
Black	8.5	8.1	10.2

Needle aspiration of the cul-de-sac has been proposed as a method of screening by evaluating for malignant cytology. This procedure is impractical, however, and is very uncomfortable to patients.[6] In 1971, Barber[7] introduced the term, the postmenopausal palpable ovary syndrome. This stresses the importance of the fact that if an ovary is palpated

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in a post-menopausal patient, she should be evaluated as if that ovary were malignant.

Staging and Management

The accepted staging for ovarian cancer is a surgical assessment in accordance with guidelines of the Cancer Committee of the International Federation of Gynecology and Obstetrics (Table 2).

A careful operative assessment of the location and the extent of the disease is extremely important. Special attention must be paid to the undersurface of the right hemidiaphragm. Many times, tumors felt to be limited to the pelvis will have sub-diaphragmatic seedings.

Proper management requires consideration of the patient's general health, stage of disease, and histologic cell type and grade. The total management of the patient is best decided by the team approach, involving the pathologist, gyn-surgeon, radiation therapist, social worker, and nursing staff.

The pathologic tumor grade and stage are important predictors of a case's prognosis.[8, 9] The single most important predictor of prognosis is the size of tumor masses which remain after surgery.[8] It is, therefore, important that maximal surgical effort be made at the initial exploration. The surgical procedure of choice in the management of ovarian cancer is total abdominal hysterectomy, bilateral salpingo-oophrectomy, omentectomy, and appendectomy — the goal being the removal of as much of the diseased tissue as possible without inordinate patient morbidity.[1]

Less than this radical approach is reserved for those select cases in young patients with early staging and a favorable pathology report.[10] Selected early stage germ cell tumors may be approached in this manner, along with adjuvant radiation and/or chemotherapy.

Chemotherapy in this country is by far the most widely selected form of adjuvant therapy. Initially, the alkalating agents were most commonly used and generally had an overall response rate of 50%. Recent literature has focused on multiple agent chemotherapy schedules. With greater understanding of the cell biology and the pharmacology of chemotherapeutic agents, a well-structured, multiple-agent protocol enhances the effectiveness of the therapy without significant additive toxicity.[11] Careful organ system monitoring is a must with such therapy.

In this country, external radiation therapy is generally not considered as good an adjuvant therapy as is chemotherapy. However, there is recently published Canadian data[12] which show that radiation therapy is extremely beneficial in treating advanced ovarian cancer, especially in cases where minimal disease is left postoperatively. Radiation therapy has an important place in the treatment of ovarian dysgerminomas, since this variety of germ cell cancer, a homologue of the testis seminoma, is extremely radiosensitive.

Summary

Ovarian cancer has profound implications for the Georgia practitioner. With increases in standard of living and urbanization, we are witnessing an increased incidence of this disease statewide. A carefully performed pelvic examination is essential to making a diagnosis. Maximal initial surgical effort, consideration of tumor histology, and well-planned

TABLE 2 — Staging of Carcinoma of the Ovary

Staging is based on findings at clinical examination and surgical exploration. The final histologic findings (and cytologic, when required) after surgery are to be considered in the staging.

Stage I:	Growth limited to ovaries
Stage IA:	Growth limited to one ovary; no ascites
	(i) No tumor on external surface; capsule intact
	(ii) Tumor present on external surface on capsule(s) ruptured or both
Stage IB:	Growth limited to both ovaries; no ascites
	(i) No tumor on external surface; capsule intact
	(ii) Tumor present on external surface or capsule(s) ruptured or both
Stage IC:*	Tumor either stage IA or IB, but with ascites present or with positive peritoneal washings
Stage II:	Growth involving one or both ovaries with pelvic extension
Stage IIA:	Extension to uterus or tubes
Stage IIB:	Extension to other pelvic tissues
Stage IIC:	Tumor either stage IIA or IIB, but with ascites present or with positive peritoneal washings
Stage III:	Growth involving one or both ovaries with intraperitoneal metastases outside the pelvis or positive retroperitoneal nodes or both. Also, tumor limited to true pelvis with histologically proven extension to small bowel or omentum.
Stage IV:	Growth involving one or both ovaries with distant metastases. If pleural effusion present, there must be positive cytology to allot a case to stage IV. Parenchymal liver metastasis is Stage IV.
Special:	Unexplored cases that are thought to be ovarian carcinoma

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* Peritoneal effusion that, in the opinion of the surgeon, is pathologic and/or clearly exceeds normal amounts.

chemotherapy are all necessary for proper clinical management.

Acknowledgement

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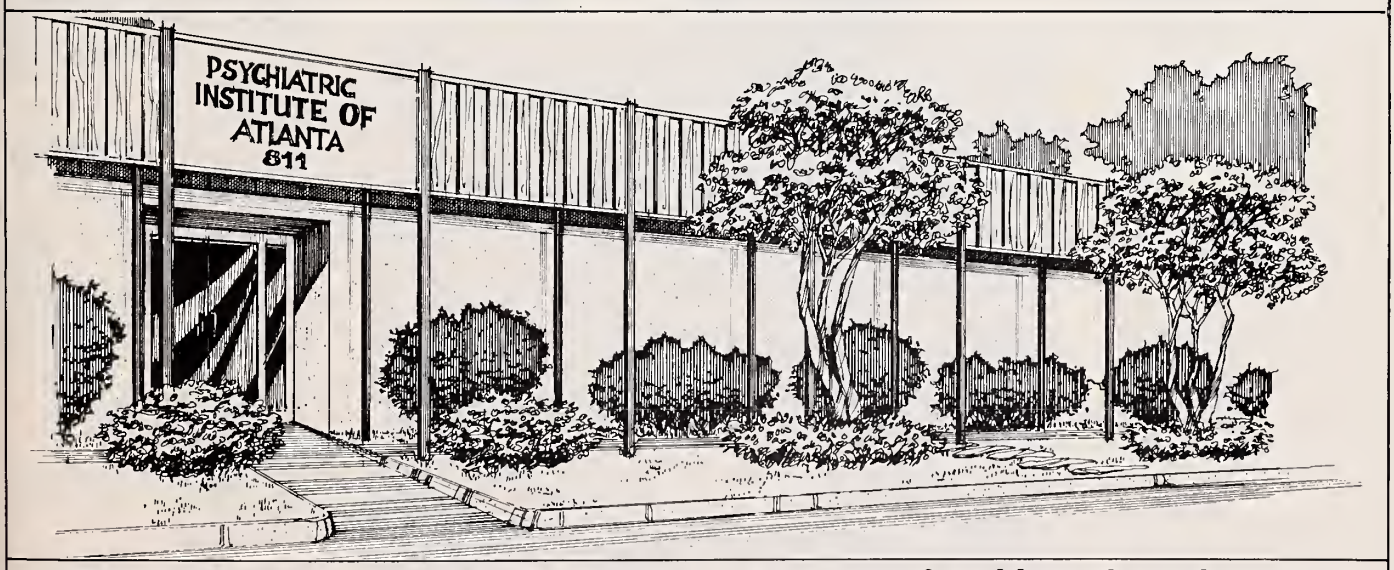
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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALDSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CRDSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [10025R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46285

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Carolina, Puerto Rico 00630

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Obesity and Surgery

Morbid obesity which does not respond to conservative medical treatment becomes a surgical entity, and the abdominal surgeon is called upon to perform an operation to help the patient lose weight. Today there are two procedures for the management of morbid obesity: 1) jejunoileal bypass and 2) gastric stapling or bypass procedures.

Both procedures, which, by the way, have several modifications, do not attack the primary cause of obesity which, according to Buchwald,[1] is of a neuro-humoral origin and/or genetically linked. They do produce either malabsorption (jejunoileal bypass) or minimal food intake by making a "small stomach" (gastric bypass, gastric partition, gastroplasty). Each procedure has its own problems, enthusiastic followers, and enthusiastic enemies, if the word "enemy" is permissible.

The complications of jejunoileal bypass are well known: liver cirrhosis, arthritis, nephrolithiasis secondary to calcium oxalate, cholelithiasis, diarrhea, proctitis and periproctitis, fluid and electrolyte problems, and osteomalacia, to mention just a few.

The gastric procedures do not have metabolic problems, but early and late complications such as nausea and vomiting, dumping syndrome, anastomotic or partitioning problems, and failure to lose weight have been reported.

Since conservative treatment of morbid obesity has a 99% failure rate, the surgeon has to choose between a jejunoileal bypass or one of the gastric procedures, such as gastric partition, gastric bypass, gastroplasty, truncal vagotomy, or jaw wiring.

The literature is rich with reports of both malabsorption and intake reduction procedures. The reader, however, can be confused. For example, Nachlas, et al.[2] states that the operation of choice is the end-to-side jejunoileal anastomosis. Carey[3] supports gastric partitioning, and he believes that this type of procedure will approach the ultimate success rate for the treatment of morbid obesity.

Kral[4] successfully treated 11 patients with truncal vagotomy. Griffen[5] supports gastric bypass and Gomez,[6] in the same issue, supports gastroplasty. Brolin and Ravitch,[7] in an excellent experimental work, reported that mucosa-to-mucosa stapling is not a reliable technique. H. W. Scott, Jr.,[8] reports good results with jejunoileal bypass.

It is not within the scope of this editorial to review the surgical treatment of morbid obesity. To be dogmatic about either procedure is highly unscientific. Individualization for each case is a wise approach. The careful selection of patients is paramount. Detailed discussions with the patient and family as well as informed consent is a must. No promise should be given for the success of either surgical procedure, since the results are so unpredictable. Surgery does not attack the primary cause of the problem, but rather the end point of the disease. Furthermore, the surgery does have its risks.

Presently, it is impossible to say if the more easily performed jejunoileal bypass, with its metabolic problems, is better or worse than the gastric bypass, with its technical problems and early complications.

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Coalitions — The New Influence on Health Care Costs

THE MUCH-SOUGHT REMEDY for increasing health care costs has not been found as yet by regulatory or legislative bodies. Some observers believe that the heralded pro-competition legislation, if enacted, may take 10 years or more to become effective. In the meantime, a new private-sector organization, the business-medicine-labor-insurer-hospital coalition, is being formed in this country to deal with the issue of rising health care costs. These coalitions typically are led by the employers of an area who are motivated to contain health care cost increases for their employees. Labor representatives are involved because most health care benefits of employees are negotiated by labor. Providers are included because hospital care generates much of the cost increases and because physicians control and prescribe a large portion of health care services. Insurers have been involved in financing most of the private-sector health care and are facing the possibility of employers' self-insuring to control costs.

The potential is there for negotiating important changes in the health care market place, including cessation of first dollar insurance coverage and the institution of appropriate co-payment mechanisms. Effective concurrent utilization review and technology and facility reviews can be put in place. Reimbursement for hospital services can be arranged to reward efficiency and cost effectiveness rather than on a cost-plus basis. Hospitals and physicians whose charges are high can have economic pressure applied by insurers and employers and patients.

The economic forces which can bring about these and other changes have heretofore not been organized to exert effective pressures on the system, but through the coalition movement, they now seem much more likely to occur.

We at the MAG are attempting to join with the formation of coalitions in our state and believe that much can be accomplished by the private sector without regulation and legislation. Let us hope that this proves to be the case.

L. Newton Turk, III, M.D.

(Continued from "Heart Page," p. 358)

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Recent Advances in the Diagnosis of Coronary Artery Disease

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THE NUMBER of noninvasive techniques used in the diagnosis of coronary artery disease (CAD) has recently increased. Although exercise electrocardiography (ECG) remains the most widely used test,[1, 2] Holter ECG, cardiac fluoroscopy, myocardial perfusion scintigraphy, cardiokymography, echocardiography, and blood pool scintigraphy are of value in the diagnosis of CAD. Owing to the high cost of diagnosis and management of CAD, an accurate, inexpensive, and preferably nontraumatic diagnostic procedure is needed.

Despite the low cost and morbidity of the traditional exercise ECG, this test has been recently criticized as being too unreliable for detecting CAD, with a sensitivity of 38%-65% if ST segment displacement is the only criterion of abnormal response used. However, a much higher sensitivity (up to 90%) has been reported when additional criteria, such as the response of blood pressure or the appearance of chest pain or S_3 gallop sounds, were employed. As expected, very high figures for sensitivity (98%) can be reached by combining this test with either MUGA or Thallium exercise scintigrams.[3]

Blood pool scintigraphy using technetium pyrophosphate (the MUGA scan), a technique for imaging of the left ventricular (LV) cavity in a fashion analogous to that of LV angiography, provides estimates of LV ejection fraction and allows for analysis of segmental LV wall motion which is usually affected by clinically significant coronary obstruction. A promising modification of this test permits observation on the response of LV wall motion and ejection fraction obtained by MUGA during exercise (exercise MUGA test) as compared with values at rest. In contrast to the increase in ejection fraction observed in normal hearts on exercise, patients with significant degrees of CAD often demonstrate no change or even a decrease in ejection fraction during effort, appearance of (or intensification of pre-existing) LV wall motion abnormalities, or both. This technique is particularly sensitive and, in controlled series, abnormal responses were obtained in as many as 94% of all patients with proven CAD.[4]

Myocardial scintigraphy uses Thallium 201, an isotope taken up by a normally perfused myocardium but not by a damaged or ischemic one, which is depicted as a defect or "cold spot" on the scintigram. Although such permanent defects are found in myocardial infarction, the amount of myocardial ischemia in regions perfused by critically obstructed arteries is seldom severe enough to be demon-

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strated by Thallium scan at rest and can be overlooked. Precipitation or augmentation of pre-existing myocardial ischemia by exercise permits detection of such poorly perfused areas by Thallium, with subsequent disappearance of the defect in follow-up images obtained 3-4 hours later at rest. The reported sensitivity for exercise Thallium scintigraphy ranges between 56% and 87%, with a specificity of 92%.[4] The test is indicated as follows: 1) In patients with inconclusive exercise ECG; 2) when the coronary arteriogram is equivocal; 3) to assess the viability of myocardium; 4) to assess the extent of myocardial damage following myocardial infarction; 5) for follow-up after medical or surgical treatment; and/or 6) to improve medical management in uncertain cases when both the physician and the patient will be satisfied with a negative result.

Except for limited occasions of narrowing of the left main coronary artery, echocardiography has not yet been successful in directly visualizing existing coronary arterial obstruction. Its contribution, however, in the diagnosis of CAD is remarkable, since it can provide information about the consequences of significant narrowing of the coronary arteries on the function of LV myocardium irrigated by them as well as an estimate of the overall performance of the left ventricle, the presence of intracardiac thrombus, etc. The reliability and image quality of the 2-dimensional echocardiography is comparable or even superior to that of LV angiography and, because of its much lower cost and lack of associated risk, this technique is ideally suited for repeated applications on a given patient for purposes of follow-up. A recent review of the role of echocardiography in the detection and management of CAD has been published.[5]

Because none of these noninvasive tests is free of error, a multiple approach would permit a more accurate diagnosis of CAD, particularly if more than one vessel were involved.[6] Thus, the predictive accuracy of an ECG exercise stress test is increased if the test is supplemented with Thallium stress scintigraphy. An abnormal ECG stress test in a totally asymptomatic patient combined with positive fluoroscopy for coronary arterial calcification is associated with a high incidence of CAD.

Certain limitations in the use of multiple tests for a given patient are recognized. First, although the concordance of results of two or more tests increases the likelihood of their being correct, it does not necessarily provide additional information on the extent of CAD over that obtained by either single test. Second, when the results of two or more diagnostic tests are discordant, the decision on further management remains problematic. Third, indiscriminate use of multiple tests remains prohibitively expensive.

The ultimate test for detecting and quantifying anatomical lesions of the coronary arteries is coronary angiography, a technique used ever increasingly in the last decade. Technologic advances have markedly increased the clarity of the angiographic images and the variety of different views obtained with a smaller number of injections. In addition, pharmacologic interventions during coronary angiography permit distinction between fixed atherosclerotic lesions and reversible vasospastic coronary arterial narrowing which is responsible for Prinzmetal's angina. The LV angiogram, routinely obtained before coronary angiography, provides valuable information on the global and regional function of LV myocardium, an important determinant of surgical risk and long-term prognosis. Owing to their invasive nature, these studies are potentially harmful, but their morbidity is acceptable (0.15%) and the mortality low (less than 0.1%), provided they are performed by experienced personnel.

In summary, the rational assessment of patients with possible CAD dictates the use of the least expensive, the least invasive, and the most accurate among the currently available noninvasive techniques. The ultimate decision for the performance of invasive studies should be made on an individual basis after careful consideration of the clinical and laboratory data and of the risk/benefit ratio associated with cardiac catheterization.

(References are listed on page 356.)

The Employer's Rights and Responsibilities in Hiring and Firing Employees

DARA DeHAVEN, *Atlanta**

ONE OF THE MOST significant and recurring problems facing the employer today is the effective hiring and firing of employees. This is particularly true when the number of employees is small and the employer has not developed standard personnel policies and procedures for hiring, disciplining, and firing employees. By failing to adequately document personnel actions, many employers significantly increase their unemployment tax rate. Furthermore, in a work environment that is increasingly oriented to employees' rights, employers face a rising tide of employment discrimination complaints filed under federal and state equal employment opportunity laws. Without sufficient documentation of the employee's poor work record in the personnel file, defending such discrimination claims can be a costly and time-consuming experience. Furthermore, if unsuccessful, the employer may be required to reinstate the unwanted employee, to provide back pay, and to pay the employee's attorney's fees.

This article will outline a Georgia employer's rights and responsibilities and suggest ways to limit or reduce liability under the Georgia Employment Security Law, Georgia employment discrimination laws, and federal employment discrimination laws.

Georgia Employment Security Law

The Georgia Employment Security Law provides financial assistance to those individuals who lose their jobs through no fault of their own and are unable to find other employment. This law applies to physician employers having only one employee as well as to the large professional corporation or association having many employees. Employers pay the entire cost of the unemployment program by making quarterly tax payments to the state Unemployment Compensation Fund. An employer may obtain a reduction in tax rate if the number of unemployment compensation claims charged against his account is relatively low. If an employer is careful to document the facts when an employee is terminated, it is possible to obtain a reduction of taxes paid to unemployment compensation.

In order to administer unemployment claims, the Georgia Employment Security Agency requires all employers to complete Georgia Form ESA-800, Separation Notice, for each worker separated from the company, regardless of the reason for separation. In accordance with the printed instructions contained on the Form, this Separation Notice must be completed, dated, and delivered to the separated

* Prepared at the request of the Medical Association of Georgia. Ms. DeHaven is an Associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

employee on the last day of work. A copy of this form must be presented to the Employment Security Claims Center by the individual filing a claim for unemployment insurance. Copies of these Forms may be obtained by calling the Georgia Department of Labor (404/656-3000) or by writing to the Georgia Department of Labor, Employment Security Agency, 254 Washington St., SE, Atlanta, GA 30334.

All facts and details of dismissal must be shown in the remarks section of the Employee Separation Form. It is important to explain clearly and in detail the reason for the employee's separation since the employee may be disqualified for benefits as a result of the reasons underlying his or her dismissal. For example, an individual is disqualified for benefits if he voluntarily quits without good cause in connection with his most recent employment. Ga. Code §54-610(a). If an employee quits, it is best to ask the employee to sign a statement that he is voluntarily leaving his job. This statement should be placed in the employee's personnel file and should indicate the reason the employee gave for leaving.

The Georgia General Assembly recently enacted additional disqualifications for benefits for individuals who were discharged (1) for engaging in intentional conduct resulting in physical assaults or bodily injury to the employer, fellow employees, customers, patients, bystanders, or consumers; (2) for intentional conduct resulting in property loss or damages amounting to $2,000 or more; or (3) for theft, sabotage, embezzlement, or falsification of the employer's records. Ga. Code §54-610(b)(1)(2)(3).

Furthermore, an individual is disqualified from benefits for at least 4 weeks but not more than 11 weeks after he has been discharged for failure to obey orders, rules, instructions, or for failure to perform the duties for which he was employed. Ga. Code §54-610(b). However, since Georgia law places the burden of proof of just discharge or suspension on the employer, it is necessary to document completely the reason for any employee's termination on the employee's Separation Form. All incidents should be documented, such as poor attendance, violation of company rules, unauthorized absences, failure to report for work, excessive tardiness, refusal to follow instructions, or any other example of gross misconduct on the job. It is also important to detail any prior disciplinary warnings or measures taken with regard to the individual employee.

There are certain other circumstances which can cause a claimant to be disqualified for benefits until specific requirements are met. The advice of counsel knowledgeable in the employment security area should be obtained if an employer has any questions concerning the validity of an unemployment claim filed by a former employee.

Finally, all claims should be processed immediately. When an individual files a claim, part of the Form is detached and mailed to the claimant's last employer as the Notice of Claim to the Employer. The employer has 7 calendar days from the date the Form was mailed to return the completed form to the claims office indicating his agreement or disagreement with the claim and providing the basic facts contesting the validity of the claim. If the Form is not received by the claims office within 7 days, the determination as to whether the claim should be paid or not will be made solely upon the claimant's statements.

In summary, claims against you or your professional corporation or association can be reduced by maintaining complete records on each employee's job and performance status, complete documentation of the reasons for any employee's termination, and by acting immediately on all claims and reports received.

State and Federal Fair Employment Laws

In Georgia, an indefinite employment — one in which there is no employment for a specific period of time — is terminable at will by either party. Ga. Code §66-101. Generally, this means that an employer has absolute freedom to discharge any employee as long as he does not do so for a prohibited reason. There are, however, specific statutes which limit the discharge of an "at-will" employee. For

instance, both federal and state laws prohibit an employer from discharging an employee when his wages are garnished for a *single* indebtedness, regardless of how many summons or levies the employer received for that single indebtedness. There are no restrictions on discharges when the employee's wages are garnished for more than one indebtedness. Ga. Code §46-303; 15 U.S.C. §1674.

Furthermore, all Georgia employers are subject to the Georgia Age Discrimination Act, regardless of the number of individuals employed. Ga. Code §54-1102. This Act prohibits an employer from refusing to hire, employ, or license, or bar or discharge from employment any individual between the ages of 40 and 70 years solely upon the basis of age. Violation of this Act is a misdemeanor, and persons or corporations convicted of a violation will be subject to a fine of not less than $100 or more than $250.

Several additional statutes may be applicable to physician employers in Georgia, depending upon the number of employees they have. For example, the Georgia Equal Pay Act applies to all employers with 10 or more employees. Ga. Code §§54-1001 *et seq*. The Equal Pay Act prohibits wage differentials based on sex. Men and women employed in the same establishment on jobs that require equal skill, effort, and responsibility and which are performed under similar working conditions must be paid the same. This Act does permit differences based on factors other than sex, such as a seniority system, a merit system, or a system which measures earnings by quantity or quality of production. Any employer who violates the provisions of the Equal Pay Act is liable to the affected employee for the full amount of unpaid wages which would have been paid but for the employer's discrimination.

Claims by a disgruntled employee against an employer can be reduced by maintaining complete records on each employee's job and performance status and on the reasons for any employee's termination.

All Georgia employers having 15 or more employees are also subject to the Handicapped Discrimination Act which was passed in the last session of the Georgia General Assembly. Ga. Code. §§66-501 *et seq*. This Act provides that Georgia employers may not discharge, refuse to hire, or discriminate against any handicapped individual with respect to wages, rates of pay, or other terms and conditions of employment unless such handicap restricts that individual's ability to engage in a particular job or occupation for which he or she is eligible. Furthermore, an employer may not limit, segregate, or classify a handicapped individual in any way that tends to deprive him or her of employment opportunities unless the individual's handicap constitutes a bona fide and necessary reason for such limitation, segregation, or classification. A handicapped person may bring a civil suit in state court against an employer for alleged prohibited conduct. If a violation is found, a court may order such remedies as it deems appropriate, including an injunction, reinstatement or upgrading, and admission to on-the-job training programs.

Georgia employers with 15 or more employees are also subject to the requirements of several federal employment laws. Title VII of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, religion, sex, or national origin. As amended, Title VII also prohibits discrimination based on pregnancy, childbirth, and related medical conditions. 42 U.S.C. §2000e *et seq*. Additionally, the Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age. 29 U.S.C. §§621-634. This Act protects individuals who are at least 40 but less than 70 years of age. Moreover, the Equal Pay Act of 1963 prohibits wage differentials based on sex. 29 U.S.C. §206. The United States Equal Employment Opportunity Commission (EEOC) is charged with enforcing these federal statutes. Thus, before a private suit can be filed against the employer, the employee

or applicant for employment must file a written charge with the EEOC within 180 days after the alleged act of discrimination.

In order to minimize and defend against charges of discrimination that will inevitably be filed by disgruntled employees, the employer should document all personnel activities thoroughly and anticipate the potential for being required to explain each employment decision and personnel practice to demonstrate compliance with the Equal Employment Opportunity obligations. The employer should review application forms to insure that no question suggests possible discrimination. For example, the application form should not contain questions regarding race, sex, or religion. This information can be collected for statistical purposes after hiring the employees and kept on a separate form which is maintained apart from other personnel records. Questions regarding citizenship should be limited to, "Are you a U.S. citizen?." Requiring applicants to designate their citizenship could subject the employer to a charge of discrimination on the basis of national origin.

Employers should also examine their personnel policies to ensure that wages and salaries do not include prohibited differentials based on race, sex, national origin, color, or age. The employer should take steps to ensure that all interested employees are considered for promotion. If performance evaluations enter into promotion selection, those evaluations should be as objective as possible.

Finally, it is important to document developing work problems. As a test to determine if your records are adequate, pick an employee who is a "marginal" employee, at best, and look at his or her personnel record. If the record shows that this employee looks average or better, then be assured you would have difficulty justifying and sustaining any disciplinary action you might want to take against that employee.

Also, in disciplining employees, the employer should ensure that his employment policies are enforced consistently and uniformly. Disciplining employees is an undesirable task, but it is a necessary one if an employee is to fully understand what is expected of him. Disciplinary action should always be corrective, with the purpose of changing the employee's attitude or work habits to help him to become a better employee. Employees should have an opportunity to tell their side of the story. When discipline is approached with this philosophy, it is easy to see that both the employee and the employer gain if the action is successful. If, however, after working with an employee for a reasonable period of time, it becomes apparent that the corrective action is not doing any good, then termination is absolutely essential. The longer the employer prolongs the ultimate decision to discharge, the worse it is for the employer, and it becomes more difficult to defend the discharge when a charge is filed with a governmental agency. Once the decision to discharge an employee is made, the employer should carefully process all the required forms and put only objective, documented reasons for the termination on separation notices and payroll stop orders.

Even when employees have been treated fairly and disciplinary action is called for, some charges may still be filed with the EEOC. If an employer receives a charge, he should have an attorney knowledgeable in employment discrimination law review the entire record. The employer should not respond to the EEOC without advice of counsel. This is important because the EEOC may expand the case on the basis of information supplied by the employer. It is also important to investigate the charge immediately and secure written statements from all fellow employees with knowledge of the event. Records relating to the charge of discrimination should be preserved. Finally, the employer should avoid any retaliation against the individual filing the charge.

In conclusion, employers' decisions concerning the hiring, disciplining, and firing of employees are increasingly coming under careful scrutiny by government agencies and courts. To reduce the amount of unemployment compensation taxes and to defend against charges of discrimination, employers should be careful to make personnel decisions on a non-discriminatory basis and to document all incidents leading up to an employee's discipline or termination.

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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 μg/ml and 0.09 μg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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president's letter



Ongoing and Upcoming Challenges for Medicine

MEDICINE IN GEORGIA has been characterized by strong and distinguished leaders at both state and national levels — in the MAG, the specialty societies, and the AMA. It is, therefore, a signal honor for me to be allowed to serve as president of the MAG and to follow this tradition of leadership.

The years just ahead will test the metal of us and our organizations. The end of the "Golden Age" of the free, fee-for-service practice of medicine might be approaching — unless we are both wise and energetic enough to help the profession, the government, and the public reach reasonable solutions to the incredibly complex problems facing all of us. We physicians, perhaps through apathy, have allowed some of these problems to develop. We certainly, however, have the knowledge and insight to help find constructive answers.

Our major challenges will be to find ways to:

1. limit health care costs;
2. allocate finite medical resources appropriately;
3. establish meaningful coalitions between business and medicine;
4. develop closer relationships with medical educators in an effort to persuade them to teach young physicians the business and art of medicine as well as they are teaching the science of medicine;
5. influence the legislature to effect the necessary tort reforms to minimize the destructive menace of unbridled malpractice litigation;
6. complete the establishment of the physician-owned professional liability insurance company;
7. educate people about their necessary role in maintaining good health and managing their own health problems.

These are mammoth tasks that cannot be accomplished in a single year or even in several years. Yet no one has promised that it would be easy. We have to start somewhere.

I am asking a small group of our colleagues to serve as a task force to organize a plan of action. If things go well, officers in succeeding years may want to continue this effort. The alternative is that someone else will do this planning for us.

The prospects are for MAG to have an active and eventful year. The membership has the responsibility to stimulate those of us in leadership positions to work hard and accomplish much. I believe we are ready to respond.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.
President, MAG

NEW MEMBERS

Bailey, Thomas E., Jr., Richmond—ACT—OBG
820 St. Sebastian Way, Augusta 30910

Bellam, R. R., Glynn—ACT—AN
3215 Shrine Rd., Brunswick 31520

Bellam, Samara S., Glynn—ACT—IM
3215 Shrine Rd., Brunswick 31520

Brogdon, Joseph M., Jr., Bibb—ACT (N-2)—IM
Baconsfield Office Park, Bldg. 3, Macon 31204

Burnett, Omer L., Dougherty—ACT—R
417 Fourth Ave., Albany 31702

Carman, John S., Cobb—ACT—P
3188 Atlanta St., Smyrna 30080

Clements, Larry V., Cobb—ACT (N-2)—PD
833 Campbell Hill St., Marietta 30090

Collins, David R., Cherokee-Pickens—ACT (N-2)—IM
110 Waleska Rd., Canton 30114

Dedonis, James L., Hall—ACT (N-2)—IM/CD
667 Lanier Park Dr., Gainesville 30501

Fisher, John F., Richmond—ACT
Medical College of Georgia, Augusta 30912

Goodman, Carey W., Ogeechee River—ACT (N-2)—FP
407 Zetterower Ave., Statesboro 30458

Gregg, Patricia M., Cherokee-Pickens—ACT—AN
307 Hembree Hill Rd., Canton 30114

Harvey, Dennis W., Cobb—ACT—AN
1001 Thornton Rd., Lithia Springs 30057

Hill, James W., Hall—ACT (N-2)—OBG
1100 Vine St., Gainesville 30501

Hudson, William H., Richmond—ACT—ORS
820 St. Sebastian Way, Ste. 8, Augusta 30910

Hutchins, Julian C., Sr., McDuffie—I & R—GP
600 Ware St., Thompson 30824

Knowles, James B., Meriwether-Harris-Talbot—ACT—PM
P. O. Box 130, Warm Springs 31830

Krawiecki, Nicolas S., Richmond—ACT—PD
Medical College of Georgia, CK286, Augusta 30912

Levin, Fred A., Newton-Rockdale—ACT (N-2)—IM/GE
1309 Milstead Rd., Suite G, Conyers 30207

McNatt, Jim H., Cobb—ACT (N-2)—OPH
653 Cherokee St., Marietta 30090

Mooney, Al J., III, Ogeechee River—ACT (N-1)—FP
Willingway Hospital, P. O. Box 508, Statesboro 30458

Patel, Thakor B., Cobb—ACT—AN
Box 517, Austell 30001

Patton, Mary Lee, Bibb—ACT (N-2)—IM
949 Boulevard, Macon 31204

Prasad, Rayasam V., Clayton-Fayette—ACT (N-1)—AL
425 Forest Parkway, Forest Park 30050

Steele, John C. H., Jr., Richmond—ACT (N-2)—PTH
Clinical Pathology Labs, MCG, Augusta 30912

Toraya, Jules, Georgia Medical—ACT (N-2)—OBG
2512 Habersham St., Savannah 31401

Watkins, Patricia, Richmond—I&R—P
Dept. of Psychiatry, MCG, Augusta 30912

Zarzuela, Ricardo I., Jr., Ware—ACT (N-1)—FP
1408-B Tebeau St., Waycross 31501

PERSONALS

First District

Fred J. Coleman, M.D., was recently presented a plaque in recognition and appreciation for his 10 years as chairman of the Laurens County Board of Health. Dr. Coleman has been instrumental in numerous accomplishments in both the physical and mental health programs in Dublin and Laurens County.

Second District

M. A. Ehrlich, M.D., of Bainbridge, was honored in a local newspaper on the occasion of his 88th birthday. Dr. Ehrlich is one of the five oldest practitioners in the state of Georgia. He received his medical degree from Vanderbilt University School of Medicine and interned at Bellevue Hospital in New York City. He returned to Bainbridge in 1918 and has practiced there for 64 years.

Third District

Columbus physician, **Micki Souma, M.D.,** received the Service to Mankind Award in March for her work in establishing the obstetrical teaching program at the Medical Center and in developing programs to assist rape victims. She also supported the development of advanced newborn care at the Medical Center. The Service to Mankind Award is given annually by the Sertoma Clubs to an

individual exhibiting humanitarian traits. Dr. Souma is president of the Georgia Prenatal Association and co-director of the March of Dimes Genetic Counseling Service. She is married to Dr. C. Daniel Cabaniss.

Fourth District

Alexander T. Parkinson, M.D., is the recipient of the 1981 Julius McCurdy Citizenship Award. The award is presented annually by Decatur Federal Savings and Loan Association and the DeKalb Medical Society and recognizes a member of the Society for services to the community. Dr. Parkinson was recognized for his participation in the DeKalb County school health program.

Fifth District

The Physician of the Year Award was presented to **James Palmer, M.D.,** at a recent banquet of the Medical Association of Atlanta. Dr. Palmer was cited for his many years of outstanding service.

Oncologist **Stan Winokur, M.D.,** was the speaker at a cancer seminar held recently at St. Joseph's Hospital. The seminar was the first in a monthly series sponsored by St. Joseph's new Speakers Bureau. Dr. Winokur was a principal organizer of the Speakers Bureau. Future topics will include nutrition, heart disease, stress management, and diabetes.

William J. Morton, M.D., recently passed the oral and written examination of The American Board of Quality Assurance and Utilization Review Physicians, Inc.

Atlanta physician, **Joseph I. Miller, M.D.,** assistant professor of thoracic and cardiovascular surgery at Emory University School of Medicine, has been elected to a 2-year term as president of the Georgia Thoracic Society. **C. Neil Kelley, M.D.,** from Emory (a non MAG member) was chosen president-elect. The secretary-treasurer will be **Garnett J. Giesler, M.D.,** from LaGrange.

On March 4, **Steven L. Jaffe, M.D.,** was named Director of Peachtree-Parkwood Hospital's Adolescent Psychiatric Program. Dr. Jaffe is Associate Professor of Child Psychiatry at Emory University and President of the Georgia Council for Child and Adolescent Psychiatry. He is a Fellow of the American Academy of Child Psychiatry.

Spencer B. King, III, M.D., lectured recently on "Treatment of Coronary Artery Disease" to members of the medical staff at John D. Archbold Memorial Hospital. This was the second R. C. Balfour Memorial Lecture. Dr. King helped develop the technique of arterial catheterization through the leg. He revealed statistics compiled at Emory University that show a high success rate with both bypass surgery and the newer coronary angioplasty technique in treating arteriosclerosis. Dr. King is head of the catheterization laboratory at Emory.

Sixth District

The Douglas County Commission recently voted unanimously to employ **Clark Robinson, M.D.,** as its county doctor. Dr. Robinson's responsibilities will include conducting employee physicals, care of county prisoners, investigating deaths, and aid in the treatment of rape victims.

Barry F. Scanlon, M.D., has recently joined the Psychiatric Institute of Atlanta as a staff psychiatrist. Dr. Scanlon received his M.D. degree from the Mayo Medical School.

Gastroenterologist, **Bruce Huckaby, M.D.,** in a recent interview for the *Macon News,* discussed the etiology and symptoms of ulcers. He noted that duodenal ulcers are four times more common than gastric ulcers, and neither is predictable, although duodenals tend to be recurrent.

Seventh District

Royal T. Farrow, M.D., of Dalton, was recently named 1981 Man of the Year. Dr. Farrow has been active in numerous community projects involving health and allied subjects. Since 1966, he has served on the Disease Committee at Hamilton Memorial Hospital. Dr. Farrow is a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics. He was cited by the Georgia Hospital Association in 1979 and presented the Gold Meritorious Service Medallion for more than 15 years of service.

Douglas D. Glover, M.D., of Marietta, has accepted a faculty position at the School of Medicine at Marshall University in West Virginia. He has served as director of the Kennestone Hospital Tumor Clinic since 1968.

Tenth District

Sherwood Reichard, M.D., Regent's professor of radiology and physiology at the Medical College of Georgia, was elected president of the International Union of Reticuloendothelial Societies at the recent Society congress in Switzerland. The group is composed of societies from the U.S., Japan, and Europe.

SOCIETIES

The semi-annual meeting of the **Second District Medical Society** was held at Chickasaw Lodge in Pelham on April 10. Elected to serve for 3-year terms were David Adcock, M.D., from Moultrie, as president; Lanny Copeland, M.D., Moultrie, vice president; Sammie Dixon, M.D., Tifton, director; Lanny Copeland, M.D., alternate director; and Frank "Dick" Miller, M.D., Thomasville, secretary-treasurer.

DEATHS

Edwin W. Allen, Sr.

Edwin W. Allen, Sr., M.D., age 91, died March 12. He was the physician and co-owner of Allen's Invalid Home and had served on the staff at Central State Hospital. Dr. Allen was a member of the Baldwin County Medical Society, the Medical Association of Georgia, the American Medical Association, the American Psychiatric Association, a member and past president of the Southern Psychiatric Association, and was elected Physician of the State of Georgia in 1982.

Dr. Allen is survived by his wife, one daughter, one son, and a brother and sister.

Don F. Cathcart

Don F. Cathcart, M.D., died March 18 at the age of 77. Dr. Cathcart received his bachelor of science degree from

Auburn University in 1925 and graduated from Tulane University Medical School in 1929. He worked on polio research with Jonas E. Salk, M.D., and later, as chairman of the Georgia Polio Campaign, helped distribute the Salk polio vaccine in Georgia.

Dr. Cathcart is survived by a daughter and son.

James Clayton Metts

James Clayton Metts, M.D., died in February at the age of 84.

Dr. Metts obtained his medical degree from the University of Georgia. For 3 years he was an instructor at the University of Georgia Medical School in Augusta. He was a past president of the Georgia Medical Society and the First District Medical Society, a former vice president of the Medical Association of Georgia, a member of the AMA, and the Southeast Surgical Congress. He was a Fellow of the American College of Physicians and the American College of Chest Physicians.

Dr. Metts is survived by a son and daughter, four sisters, and six grandchildren.

David M. Nowell

David M. Nowell, M.D., died March 19 at the age of 55. Dr. Nowell graduated from Bowman-Gray School of Medicine. He served as junior resident, senior assistant resident, and chief resident for Obstetrics-Gynecology at Crawford W. Long Hospital. He was the first obstetrics and gynecology specialist to locate in Dalton. Dr. Nowell was a Diplomate of the American Board of Obstetrics and Gynecology, a member of the American College of Obstetrics and Gynecology, the Whitfield-Murray County Medical Society, and the Medical Association of Georgia.

Jules S. Terry

Jules S. Terry, M.D., M.P.H., Director of the Family Health Services of the Division of Public Health, Georgia Department of Human Resources since 1973, died on February 22 at the age of 58. Dr. Terry provided leadership to Georgia by using perinatal epidemiology that brought national and international recognition to the Georgia maternal and infant health program.

He was one of the first Americans invited by the Chinese Medical Society to bring a group of physicians to the Peoples Republic of China to study their health care delivery system. Dr. Terry was a consultant to the Pan American Health Organization in maternal and child health in the English-speaking Caribbean countries. He led the campaign to eliminate measles in Georgia, and no cases have been reported since July, 1981.

Dr. Terry was born in London, England, and graduated from Cornell University and New York Medical College. He completed internship and residency programs in obstetrics-gynecology in Bridgeport and New Haven, Connecticut. He served in the United States Army Medical Corps in World War II.

James Randall Winburn, Jr.

James Randall Winburn, Jr., M.D., 63, died March 1. He received his medical training at Columbia University Medical School, Bellevue Hospital, and the Mayo Clinic. Dr. Winburn was associate professor of surgery at the Medical College of Georgia from 1979 until his death.

Survivors include his wife, two sons, two daughters, his father, one brother, one sister, and two grandchildren.

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CONTRAINDICATIONS: Convulsive disorders or known history of sensitivity to any of the listed active ingredients. Because of the vasodilating action of nicotinic acid, Ru-Vert should not be used in patients with hypotension.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with Ru-Vert.

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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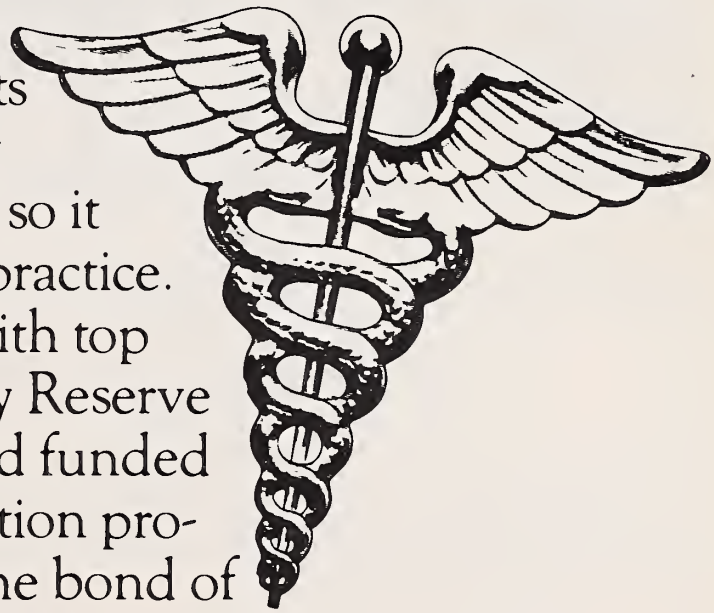
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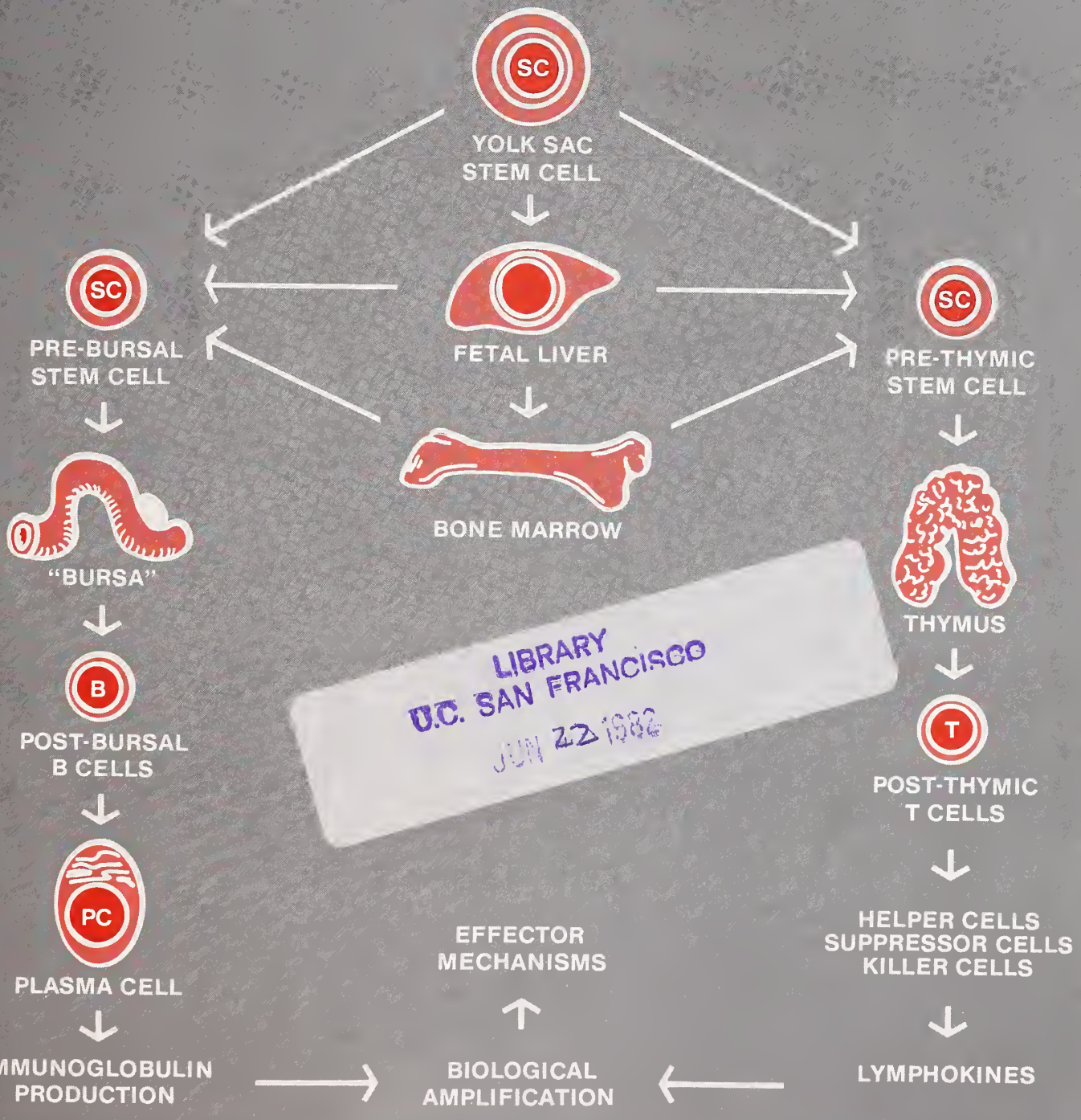
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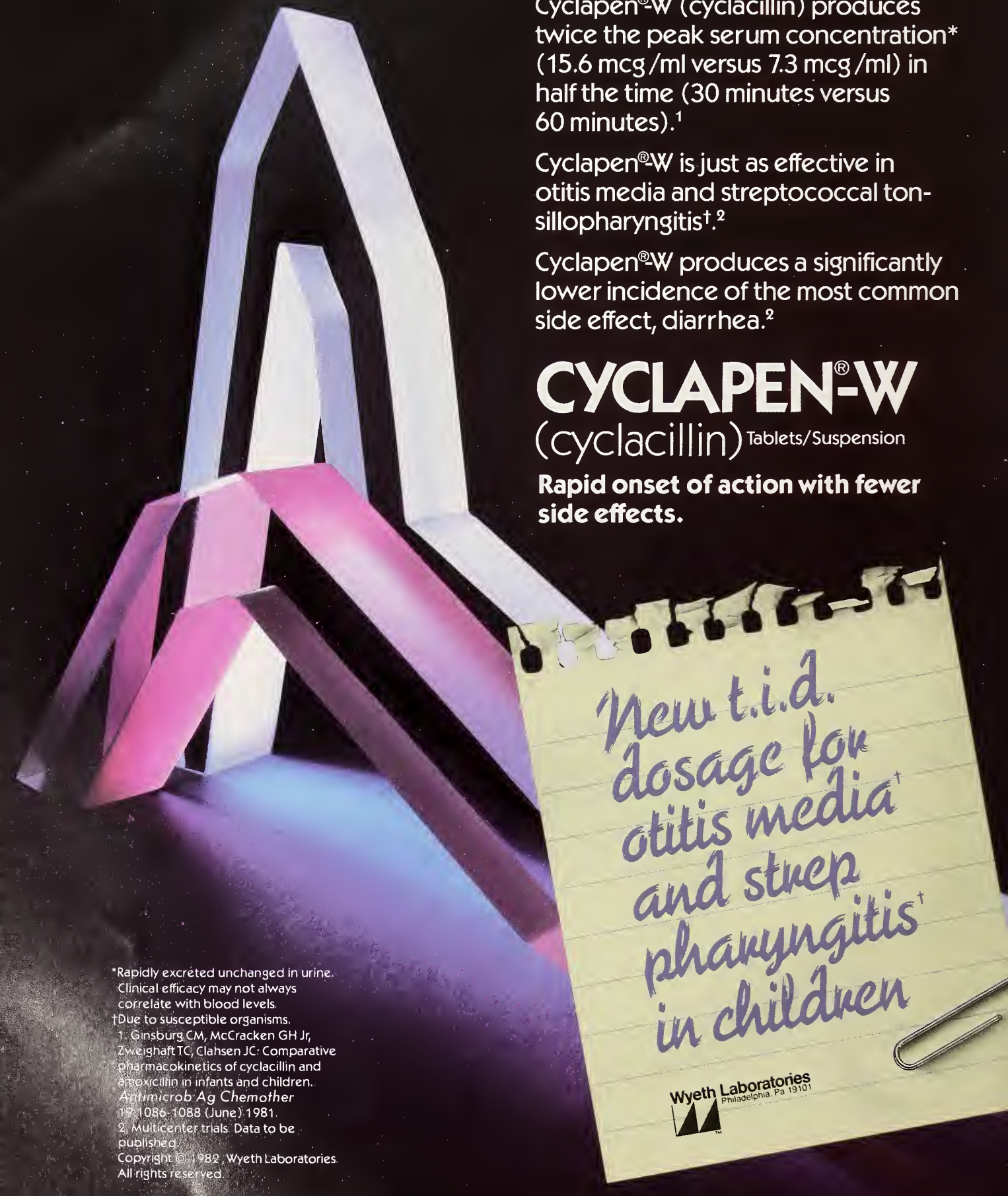
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1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.
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Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

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Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day t.i.d.†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
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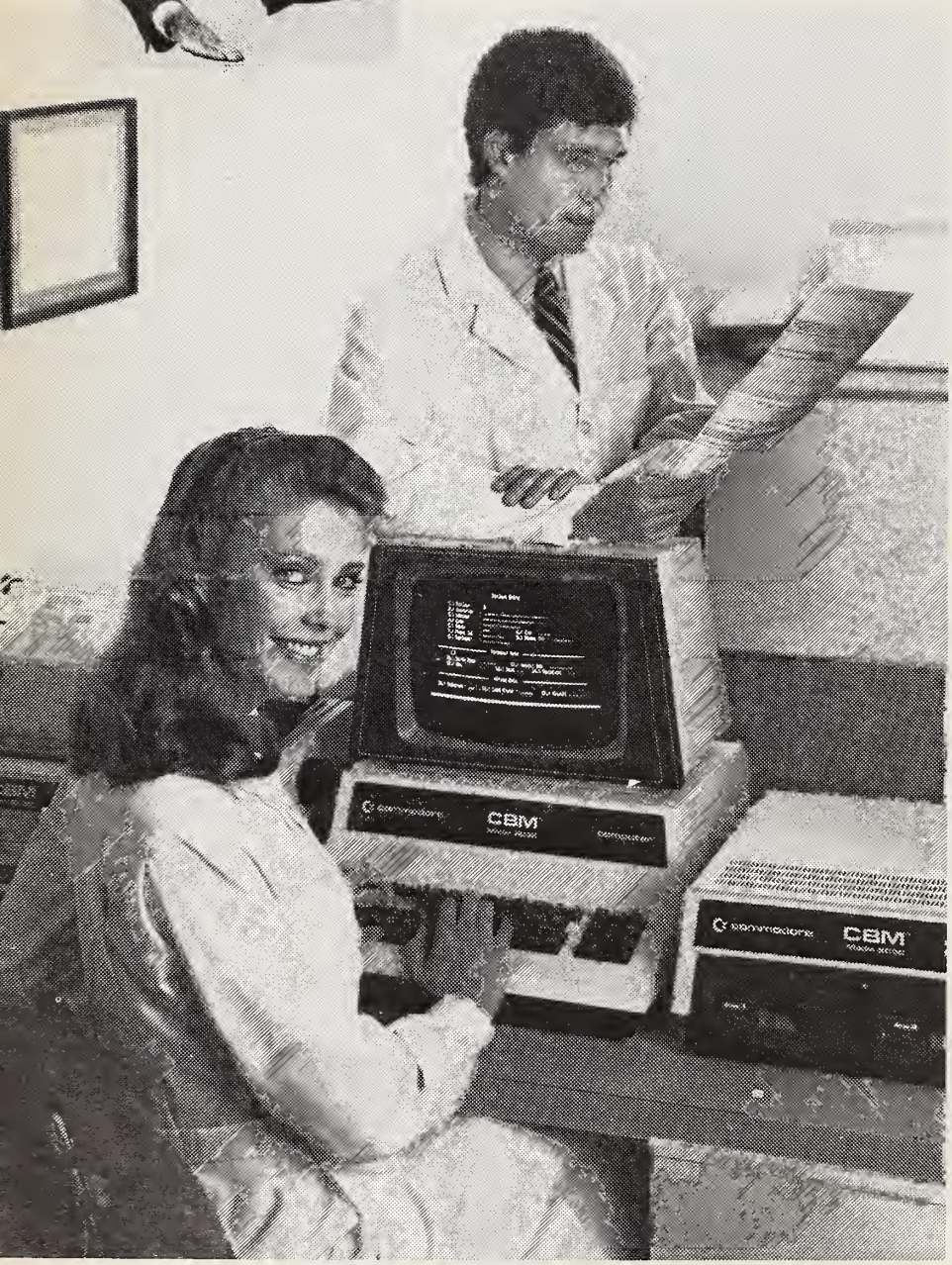
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THE COVER

This month's cover features the development of the omnipotent stem cell into specialized lymphocytes. Derangements in this process are discussed in Dr. Guill's article on page 395 on the immune system.

Cover design by Jill Harris Brown, of Atlanta.

The *Journal* would like to express sincere thanks to Wallis Kamera Haus in Atlanta for its special help in preparing the photographs of the Annual Session in time to meet the publication deadline of this issue.

Incidental Intelligence . . .

MAG Science Awards

The MAG honored two state high school students for their exhibits in the medicine and health category at this year's Georgia Science and Engineering Fair, held April 15-17 at the University of Georgia. The MAG annually provides awards for two projects deemed by the judges as exemplary in the area of medical science.

Mr. Philip West of Redan High School in Stone Mountain was awarded a first-place $100 savings bond for his project, "The Effects of Various Contributions of Nicotine in Oral Tobaccos on Erythrocytes." Miss Michelle Cobb of Norcross High School was awarded a second-place prize of $50 for "Preparation of a Karotype."

Through these awards, arranged by the MAG Committee on Education, the Medical Association hopes to show its support of good students interested in the field of medical science.

MDs Offer Cost Containment Proposals to Government

The American Society of Internal Medicine (ASIM) called on the federal government and other organizations with an interest in health care costs to consider a 10-point program of cost containment incentives.

The program, which calls for alterations in federal and private health insurance reimbursement, is based on ASIM's contention that the present system includes "perverse incentives that encourage hospitalization, which by its nature is more expensive than ambulatory care. . . ."

"Those incentives also unintentionally reward inefficiency and penalize efficiency, promote costly technical/surgical procedures instead of less-costly (and frequently more effective) personalized caring services, and discourage patients, physicians, and hospitals from becoming actively involved in holding down the costs of medical care," according to ASIM.

Among insurance system changes recommended by ASIM are:

- Incentives for ambulatory care.
- Prospective reimbursement under Medicare and Medicaid.
- Co-payments and co-insurance to promote patient cost-sharing in all private and public health insurance plans.
- Reimbursement for physicians' "cognitive" or thinking services, as a way to discourage more expensive procedure-oriented care.
- Coverage for preventive services, incentives for individuals to adopt positive health habits, and elimination of programs, such as federal price supports for tobacco, that are detrimental to health.

First Morehouse Medical Students Receive Medical Degrees and Residency Placements

Sixteen members of the Charter Class of the Morehouse School of Medicine in Atlanta — the nation's first medical school to be established in this century by an historically black institution — will soon receive their medical degrees and have been accepted into residency programs at leading hospitals around the country.

The first-year class of 24 students at Morehouse was enrolled in a 2-year curriculum in the basic medical sciences in September, 1978. The students then transferred to affiliated medical schools for their junior and senior years.

Four of the students transferred to Howard University, Washington, D.C.; seven transferred to Emory University in Atlanta; two to the University of Alabama at Birmingham; and one each to Brown University, Providence, R.I.; Louisiana State University, New Orleans; and the Medical College of Georgia, Augusta.

Louis W. Sullivan, M.D., dean and president of the medical school, said reaching this milestone means "we are nearer the reality of our dream — of fulfilling the mission of training and motivating physician candidates to establish family-care practices in underserved inner cities and rural areas."

Sullivan stated that 86% of the Charter Class students who took the national board examination passed and will graduate either this year or the following year. In addition to the 16 students who become medical doctors within the next few weeks, he said that three will graduate next year, and two are studying for their boards.

The Morehouse School of Medicine is now in transition to a 4-year institution. The class of 32 students that entered last fall will be the first to remain at Morehouse for the 4-year course and will receive the M.D. degree in 1985. The second-year class completed the Morehouse curriculum last June and has transferred to affiliated schools, and the third class will complete the 2-year curriculum at Morehouse this June.

Originator of Doctors' Day Dies

Mrs. Charles B. Almond (née Eudora Brown), of Winder, the originator of Doctors' Day, died at the age of 98 on March 23, 1982. A memorial service was held at the Winder First United Methodist Church on March 27, where red carnations, the recognized symbol of Doctors' Day, were furnished by the physicians of Barrow County. Mrs. Perry M. White, then president of the Auxiliary to the Medical Association of Georgia, attended the service.

Eudora Brown was reared in the small Georgia village of Fort Lamar and in early childhood became impressed by the medical profession's humanitarian service. Inspired by the kindness of her own family physician, she never lost interest in the profession.

In 1920, Eudora Brown married Dr. Charles B. Almond, and they moved to Winder to make their home. Gradually, she became convinced that very little was being done to honor the men and women of medicine. To remedy the situation, she suggested to her local auxiliary that a day be set aside each year to recognize the physicians of Barrow County. The suggestion met with immediate approval. A resolution was adopted in 1933 selecting for the annual observance the date of March 30, when in 1842 Georgia's Dr. Crawford W. Long first used ether anesthesia in a surgical operation.

Mrs. Almond had originally intended to honor only those physicians in Winder and Barrow County, but her idea spread over the next few years. The following year, on May 10, 1934, a similar resolution was adopted by the Auxiliary to the Medical Association of Georgia at the annual state meeting held in Augusta. Mrs. Almond's program was introduced to the Woman's Auxiliary to the Southern Medical Association at its 29th annual meeting in St. Louis, Missouri, on Nov. 19-22, 1935, and has become an integral part of Southern's program. Each year awards are given at the annual meeting of the organization for the best observance of the day. Two prized trophies are awarded: The George D. Feldner trophy, first given in 1954 by Mrs. Feldner in honor of her husband, and the Guy Smith Kirby trophy, given by Dr. and Mrs. William Ware, of Washington, D.C., in honor of Mrs. Ware's grandfather, Dr. Guy Smith Kirby, of North Carolina, first awarded in 1961.



Mrs. Charles B. Almond, Originator of Doctors' Day

On March 30, 1958, a resolution was passed in the United States Congress by the Subcommittee on Health and Science in Washington, D.C., commemorating Doctors' Day.

Today, Doctors' Day is recognized internationally and 17 states in the United States, including the District of Columbia, observe Doctors' Day on March 30. Cuba also holds a Day of Commemoration for physicians.

Further evidence of Mrs. Almond's devotion to medical science is the fact that upon her recent death her body was willed to the Emory University School of Medicine and her eyes to the Eye Bank.

[*Contributed by Evelyn Gay (Mrs. Brit B., Jr.) Auxiliary to MAG*]

1982 Legislative Seminar at Lake Lanier

Due to the overwhelming success of last year's legislative seminar, the MAG House of Delegates, at its recent Annual Meeting, approved the MAG Legislative Committee's sponsorship of a 1982 Legislative Seminar to be held on August 20-22, at Stouffer's Pine Isle, Lake Lanier.

The purpose of this seminar is to acquaint Georgia physicians with the political process. This is accomplished by having 15 Georgia legislators act as faculty for the first 125 MAG members who sign up to participate. The seminar is in a casual setting, enabling doctors, their spouses, and the legislators to get to know each other away from the Georgia capitol.

The cost, which includes two meals per day, cocktail party, hospitality room, all meeting costs, golf green and tennis court fees, is a modest $145 single and $233 double.

If you would like more information about the seminar and/or are interested in attending, contact Ms. Carol Green at MAG Headquarters, 404/876-7535 or WATS 800/282-0224.

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For those registrants who desire a comprehensive and up-to-date presentation of the principles of self psychology, an optional course in the basics of self psychology will be offered on the afternoon of Friday, October 8, 1982.

For further information, please print your name and address and mail this coupon to:
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MEDICAL MEETING CALENDAR

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20-25—*Rehoboth Beach, DE:* **Eastern Shore Medical Symposium.** Contact Sylvia Brocka, Progr. Dir., Univ. of Del., 2800 Pennsylvania Ave., Wilmington, DE 19806. PH:302/738-8151.

21-25—*Chicago, IL:* **National Board Review Course in Pulmonary Medicine.** Category 1 credit. Contact Dale Braddy, Dir. of Ed., ACCP, 911 Busse Hwy., Park Ridge, IL 60068. PH:312/698-2200.

24-26—*Washington, DC:* **American Cancer Society Conference: The Primary Care Physicians and Cancer.** AMA Category 1 and AAFP prescribed credit. Contact Nicholas G. Bottiglieri, MD. 777 Third Ave., New York, NY 10017. PH:212/371-2900.

24-26—*Kissimmee, FL:* **Urological Problems Encountered in a Clinical Practice.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

25-27—*Hilton Head Island, SC:* **Pumonary Manifestations of Systemic Disease.** Category 1 credit. Contact American College of Chest Physicians, Dept. of Ed., 911 Busse Hwy., Park Ridge, IL 60068.

JULY

21-25—*Kiawah Island, SC:* **Cardiac and Pulmonary Critical Care Medicine.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

26-28—*Kiawah Island, SC:* **Pediatric Update — 1982.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-31—*Hilton Head Island, SC:* **Fifth Annual Symposium on Contemporary Clinical Neurology.** (Sponsored by Vanderbilt Univ. Sch. of Med.) Contact Mrs. Joan Sullivan, Dept. of Neurology, Vanderbilt Univ. Sch. of Med., Nashville, TN 37212. PH:615/322-3461.

AUGUST

2-6—*Hilton Head Island, SC:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

9-11—*Kiawah Island, SC:* **Clinical Obstetrics.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

9-13—*Atlanta:* **Internal Medicine Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

29-Sept. 1—*Knoxville, TN:* **Tri-State Otolaryngology Assembly.** Category 1 credit. Contact Milton G. Yoder, MD, Ste. 204, 501 20th St., Knoxville, TN 37916.

SEPTEMBER

10-12—*Savannah:* **Digestive Diseases: 12th Annual Meeting, Ga. Gastroenterologic Society.** Category 1 credit. Contact Jack M. Averett, MD, 2300 Manchester Expressway, Columbus 31904. PH:404/323-3671.

16-18—*Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, MD, Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, x3322.

24-26—*New Orleans, LA:* **Southern Medical Association Regional Postgraduate Meeting.** Category 1 credit. Contact Jeanette Stone, SMA, P.O. Box 2446, Birmingham, AL 35201. PH:205/323-4400.

24-25—*Unicoi:* **Georgia Rheumatism Society Annual Meeting.** Category 1 credit. Contact Bill Stokes, Exec. Dir., Arthritis Found., 2799 Delk Rd., SE, Marietta 30067. PH:404/952-4254.

26-30—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

OCTOBER

4-5—*Atlanta:* **Contraception: Yesterday, Today, and Tomorrow.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-9—*Hilton Head Island, SC:* **Fourth Annual Frontiers in Nutrition.** Category 1 credit. Contact Jane M. Greene, Ga. Inst. of Human Nutrition, BD 101, MCG, Augusta 30912. PH:404/828-4861.

14-15—*Atlanta:* **Use and Abuse of Antibiotics — Old and New.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Atlanta:* **The Basic Course on Pain: Diagnosis and Management of Chronic Pain.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-17—*Sea Island:* **Georgia Orthopaedic Society Annual Meeting.** Category 1 credit. Contact James E. Averett, Jr., MD, Ste. 2010, 105 Collier Rd., NW, Atlanta 30367. PH:404/355-1798.

15-16—*Atlanta:* **ECG Interpretation & Arrhythmia Management.** Category 1 and AAFP prescribed credits. Internat'l Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

21-22—*Atlanta:* **Cardiology for the Emergency Department Physician.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

29-30—*Atlanta:* **Radiology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

30-Nov. 2—*Atlanta:* **SMA-MAG Scientific Assembly.** AMA, AAFP, ACEP, and ACOG credit. Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll-free in Ga.).



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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment,* edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Kales A *et al: JAMA 241:*1692-1695, Apr 20, 1979. **4.** Kales A *et al: J Clin Pharmacol 17:*207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **6.** Kales A *et al: Clin Pharmacol Ther 19:*576-583, May 1976. **7.** Kales A, Scharf MB, Kales JD: *Science 201:*1039-1041, Sep 15, 1978. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27:*541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*(10):25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Zimmerman AM: *Curr Ther Res 13:*18-22, Jan 1971. **14.** Kales A, Kales JD: *Pharmacol Physicians 4*(9):1-6, Sep 1970. **15.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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JOURNAL
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Evaluation of Patients Suspected of Primary Immunodeficiency Diseases

MARGARET F. GUILL, M.D., *Augusta**

THE PROBLEM of recurrent infection in a child or adult can be perplexing. How many episodes of URI, otitis media, pneumonia, impetigo, etc., are required to be "too many" is a difficult question to answer. In the patient with recurrent febrile illnesses, especially when associated with growth failure, weight loss, or chronic diarrhea, the possibility of an underlying immune defect must be considered.

Common variable hypogammaglobulinemia may have onset at any age.

When evaluating a patient with suspected immunodeficiency, one should first determine which branch of the immune system is involved — phagocytic, humoral, or cellular. Some of the following generalizations can be made:

1) Antibody deficiencies tend to predispose to infections with highly pathogenic bacteria;
2) Complement and opsonic deficiencies predispose to bacterial infections;
3) Phagocyte defects predispose to smoldering fungal or bacterial infections, frequently with unusual organisms;
4) Thymic defects, with or without associated B-cell (antibody) defects, predispose to severe viral, fungal, and bacterial infections; and
5) Allergic diseases predispose to increased incidence of URI symptoms and secondary bacterial infections.

Patients with immunodeficiency disorders most often have sinopulmonary and gastrointestinal manifestations, with relative sparing of the urinary, skeletal, and central nervous systems. The problem of differentiation of respiratory and gastrointestinal infection from allergic symptoms remains a significant one. Often there is no way to differentiate between the two without extensive investigation, though a careful history may reveal specific triggering factors which would suggest allergy.

Most of the primary immunodeficiencies have their initial manifestations in childhood. Historically, these patients have not survived childhood unless their immunodeficiencies are identified early and vigorously treated. With advances in both symptomatic treatment and immunologic reconstitution in the last several years, many of these patients are surviving to productive adulthood. Common variable hypogammaglobulinemia may have onset at any age.

Delayed hypersensitivity skin tests provide an initial screen for thymic (T-cell) function.

As a general screen for immune competency, after taking a thorough patient and family history and doing a complete physical examination, one should first obtain a complete blood count (CBC) with differential, quantitative immunoglobulin levels, (IgG, A, M, E) and complement screen (C3, C4, and/or CH50). Intradermal delayed hypersensitivity skin tests for several antigens (such as candida albicans, mumps, trichophyton) should be done. From the CBC, total lymphocyte and granulocyte numbers can be evaluated. Lymphopenia is associated with

* Dr. Guill is Assistant Professor of Pediatrics and Medicine, Section of Allergy and Immunology, Medical College of Georgia, Augusta, GA 30912. Send reprint requests to her. This article was sponsored by the Allergy and Immunology Society of Georgia. This is the first in a four-part series of articles on immunologic development and disease.

Immunologic Competence Laboratory Screen

Test	Abnormal Result	Associated Defect
WBC with differential	Neutropenia	Phagocyte defects, common variable hypogammaglobulinemia
	Lymphopenia	T-cell defects
Complement screen	Depressed	Phagocyte defects
Delayed hypersensitivity skin tests	Depressed or absent	T-cell defects, mononuclear chemotactic defect
Quantitative immunoglobulins	Depressed	B-cell defects

thymic defects. Neutropenia may occur alone or as part of several syndromes. Complement components are important throughout the process of phagocytosis of organisms. If any one component is deficient, CH50 or CH100 will be depressed. Specific C3 and C4 levels are the components for which analysis is most commonly available. Delayed hypersensitivity skin tests provide an initial screen for thymic (T-cell) function. Results of these preliminary tests can help to define areas needing further investigation. If all of these are normal, further consideration should be given as to whether more investigation is needed along several tracks simultaneously, in the case of a very sick patient. If symptoms are mild, the patient may be observed carefully.

Patients with immunodeficiency disorders most often have sino-pulmonary and gastrointestinal manifestations, with relative sparing of the urinary, skeletal, and central nervous systems.

Evaluation methods specifically applicable to the phagocytic system, humoral immune, and cellular immune systems will be considered in subsequent articles in this series.

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Highlights of the 1982 Annual Session

The Annual Session of the Medical Association of Georgia (MAG) was held at the Savannah Hyatt Regency Hotel on April 22-24, 1982. The 128th Annual Session was attended by 172 delegates, 27 alternates, 29 members (not delegates or alternates), and 16 guests, for a total registrationof 244. Forty-one county medical societies were represented at the meeting. Additionally, the Auxiliary to the MAG held its annual meeting during the House of Delegates but at this writing, no attendance figures were available.

Charles D. Hollis, Jr., M.D., an internist from Albany, was installed as president; William W. Moore, Jr., M.D., a neurosurgeon from Atlanta, was elected president-elect; and Eloise B. Sherman, M.D., a pathologist from Savannah, was elected second vice-president.

Highlights of the 1982 House of Delegates are presented here. A more complete summary follows.

Awards

MAG's 1982 recipient of the Distinguished Service Award is H. Hilt Hammett, Jr., M.D., of LaGrange. The award has been presented only 17 times since its inception 25 years ago. Dr. Hammett received the award for his meritorious and distinguished service which reflected credit and honor on the Association.

James A. Kaufmann, M.D., of Atlanta, was honored as the 1982 recipient of the Civic Endeavor Award for his outstanding public service and participation in civic activities.

The Family Physician of the Year is H. Gordon Davis, Jr., M.D., of Sylvester. The award was presented by Dr. Lanny Copeland of Moultrie.

New Liability Insurance Company

The House continued to support the establishment of the MAG Mutual Insurance Company by agreeing

to contribute another $100,000 to the efforts in getting the company going. This is to serve as a "line of credit" until escrow is broken and the firm begins writing liability policies. As of this writing, MAG Mutual has sold almost 1,500 Surplus Certificates at $1,500 each (approximately $2,250,000 has been raised).

MAG Budget

A record budget of $1,795,919 for 1982-83 was adopted by the House. MAG's fiscal year is from June 1 to May 31. Dues will remain at $225 for the fifth consecutive year despite the high rate of inflation for the last several years.

Specialty Societies

The House referred to the Board of Directors for study the recommendation aimed at giving specialty societies representation in the House of Delegates. MAG is already making available to any specialty society administrative services (bookkeeping, secretarial, dues billing, etc.) on a contract basis. Several societies have already taken advantage of this offer.

Cost Containment

The House supported the concept of a statewide coalition of physicians, businessmen, hospital leaders, labor leaders, and others, and stands ready through the Voluntary Effort to offer assistance to such groups in the attempts to control the rising costs of medical/health care and encourage component county medical societies to support and foster formations of similar local and regional coalitions.

PIP

The Physician Involvement Program (PIP) was commended and its continuance urged. PIP brings physicians to the state Capitol each day of the legislative session. More physicians were encouraged to become involved in the program.

PAs

The House reiterated a 1980 House of Delegates position that "MAG opposes the further training and certification of physicians' assistants (PAs) in Georgia unless a need for them can be clearly established."

FTC

The House directed that the Association seek passage of S. 1984 which exempts state-regulated professions from the jurisdiction of the Federal Trade Commission (FTC). The House also urged passage of H.R. 3722 which would place a moratorium on the activities of the FTC with respect to certain professions and professional associations.

HMOs, HSAs, PSROs

At the direction of the House, a brochure will be developed and disseminated containing the pros and cons relating to health maintenance organizations (HMOs). The House supported efforts to repeal PSRO. It urged that H.R. 4554 be repealed. This legislation created the national network of health systems agencies (HSAs). The House urged that Titles XV and XVI be repealed, thus eliminating certificate of need (CON) and other federal involvement in local health planning.

DUI Cases

The House directed that MAG work towards eliminating the *nolo contendre* plea for the first offense in DUI cases, supported the mandatory suspension of licenses for the first and second offense, and the revocation on the third offense. The House supported mandatory driving courses for persons convicted of DUI.

Drug Abuse

The House approved the concept of a statewide voluntary program to curb drug abuse which would include a 48-hour delay in the delivery of any amphetamine prescription; such prescriptions to be verified by a telephone call to the physician. Physicians were cautioned to guard blank prescription pads.

Principles Governing Physician/ Attorney Relations

The State Bar Association will be notified that the Medical Association has not agreed to the "Principles Governing Physician/Attorney Relationships" that the Bar is using. The House further directed the Physicians/Lawyer Liaison Committee to seek to resolve this problem with the Bar.

Hospital/Medical Staff Relations

The House directed that MAG sponsor its own conference on hospital/medical staff relations or cosponsor one with the Southern Medical Association or the American Medical Association.

Nurse Training

The House approved a nurse training resolution that MAG support all levels of nursing education, including baccalaureate, diploma, associate degree, and practical nursing; affirmed that there is no substitute for bedside teaching and practical learning; supported multiple levels of nursing education in order to make available career options in the various levels of nursing education without repetition of education. A similar resolution will be introduced into the AMA House in June.





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A Community Program for the Prevention of Sudden Infant Death Syndrome

SAUL M. ADLER, M.D., and W. SCOTT JAMES, M.D., *Atlanta**

Sudden Infant Death Syndrome (SIDS) accounts for approximately 10,000 deaths each year in infants under 1 year of age in the United States.[1] It is the leading cause of death after the first week of life in infants under 1 year of age.[2] Ninety percent of the victims are under 25 weeks of age, and the majority of these are infants 2 to 4 months of age. Sixty percent of SIDS victims are males,[3] and the syndrome is more common in non-white babies and in those in lower socioeconomic groups.[3-6] Until recently, this problem had thwarted the research physician and the primary care physician. Research over the last several years, however, has brought us closer to an understanding of SIDS and has provided some methods to prevent it.

Until 1972, it was generally believed that SIDS was due to an abrupt closure of the upper airway.[7] Then Steinschneider[5] described prolonged periods of central apnea during sleep in several infants who later succumbed to SIDS, and he postulated that death occurred as a result of a central apneic episode. Since then, strong evidence has accumulated supporting a primarily central respiratory event as the underlying mechanism causing death in these babies.[8-11] Shannon, et al[12] reported that infants who had prolonged apneic events requiring resuscitation had a decreased ventilatory response to inhaled CO_2 and higher resting alveolar levels of CO_2 compared to controls. Evidence also exists suggesting that a blunted ventilatory response to hypoxia is present in many of these babies.[13] A familial defect in the respiratory control mechanism is suggested by the findings that siblings of SIDS victims have more periodic breathing than controls and a depressed ventilatory response to CO_2.[14, 15] Steinschneider and others have observed brief apneic episodes and periodic breathing in infants with prolonged apnea requiring resuscitation.[16-18] Studies by Naeye and others have provided indirect postmortem evidence that victims of SIDS suffer similar prior bouts of apnea, periodic breathing, and bradycardia, possibly as a result of dysmaturity of respiratory control mechanisms.[8, 19]

If babies at risk for SIDS can be properly identified, then appropriate intervention in the form of monitoring for apnea and close medical supervision may prevent death and allow time for maturation of the infant's respiratory control mechanism.

We have established a program for SIDS prevention that includes identification of high-risk infants, testing for central and obstructive apnea, periodic breathing and bradycardia, provision of monitors in the home for infants shown to be at risk for prolonged apnea and bradycardia, and careful supervision of these infants via home nursing visits, record keeping of apneic spells by parents, and follow-up apnea testing.

The majority of these infants fall into one of three general categories:

Group 1 — Infants presenting with prolonged apneic spells at home who are successfully resuscitated and subsequently referred for evaluation. Generally, such infants are considered normal prior to the initial observed episode of apnea.

* Dr. Adler is a neonatologist and Dr. James is a pediatrician. They are associated with the Northside Hospital Infant Apnea Monitor Program, Atlanta. Send reprint requests to Dr. Adler, 960 Johnson Ferry Rd., NE, Suite 312, Atlanta, GA 30342.

Group 2 — Premature and term infants referred from a special nursery for evaluation prior to discharge. These infants have been previously identified as having problems related to respiratory control such as idiopathic apnea and bradycardia, and usually have required theophylline therapy or prolonged ventilatory assistance as neonates.

Group 3 — Newborn siblings of infants who have died of SIDS or siblings of infants previously enrolled in a program for prevention of prolonged apnea.

The extent of the initial evaluation of the patient is determined by the history. Infants referred for a possible prolonged apneic episode at home (Group 1) undergo a more extensive evaluation. These infants are admitted to the hospital immediately following the apneic episode and are monitored for heart rate and respiration. Evaluation includes obtaining an accurate history of the initial event and a physical examination, searching specifically for signs of sepsis, pneumonia, airway obstruction of an acute or chronic nature (micrognathia, glossoptosis, absent gag reflex, or noisy respirations while asleep), or evidence of neurologic or cardiac disease. Laboratory evaluation includes serum electrolytes, calcium and magnesium, urinalysis, EKG for corrected QT interval, chest x-ray, barium swallow, EEG, and 12-hour sleep pneumogram. The pneumogram is a continuous polygraph recording (Beckman model #R-611) of air flow at the nose using a rapid response thermistor (Yellow Springs model #421), instantaneous heart rate, and chest wall movement recorded by impedance pneumography (Tektronix model #413). If there is a history of noisy respirations, fluoroscopy of the upper airway is done with the infant asleep in both the prone and supine position and with the head turned to the side to determine if there is any intermittent airway obstruction. If the history of the episode is strongly suggestive of a prolonged apneic spell during sleep, the infant is sent home on a monitor in spite of normal studies. All infants on home monitors receive follow-up studies at approximately 3-month intervals.

Newborns referred from an intensive care nursery (Group 2) have usually already been tested, and conditions that could cause prolonged apnea have been ruled out. Further testing is usually limited to a 12-hour sleep pneumogram. Additional information is often obtained by recording esophageal pH, transcutaneous O_2 and CO_2, and oral airflow. Visual contact with the infant is maintained throughout the study, and extensive clinical notes are recorded directly on the polygraph paper of the sleep state, movement, and disturbing influences in the baby's environment. By recording both airflow and chest wall movement, apnea due to airway obstruction (absent thermistor signal) as well as that due to failure of central respiratory drive (absent thermistor plus absent impedance signal) can be identified. A positive test is identified by apneic spells greater than 15 seconds duration, shorter apneic events if associated with bradycardia, excessive periodic breathing, or absence of a regular respiratory rhythm during apparent quiet sleep. Apnea of greater than 15 seconds is the most common criteria used to identify a positive test.

If babies at risk for SIDS can be properly identified, then appropriate intervention in the form of monitoring for apnea and close medical supervision may prevent death and allow time for maturation of the infant's respiratory control mechanism.

Newborn siblings of infants previously identified as having died of SIDS or newborn siblings of infants with known prolonged apneic spells (Group 3) are tested with a sleep pneumogram at 2-3 days after birth and prior to their initial discharge from the hospital. However, such studies are not accurately predictive of future apnea throughout the first year of life.[20] Therefore, these infants are restudied in their homes at 6 weeks of age using a proprietary 2 channel recording of heart rate and impedance pneumography (Healthdyne Incorporated, Marietta, Georgia). The risk of SIDS in siblings of SIDS patients is considered to be 4 times the normal rate, but if both the first and follow-up studies are normal, the parents are advised that the risk of SIDS in their infant is probably no greater than in the general population. However, we will support a parental decision to enroll the child in a home monitor program in spite of normal testing. After 2-3 months of monitoring without any alarms and a repeat pneumogram in the home, most parents agree that continued monitoring is of no value.

The following case reports are representative of the infants in each group.

Case 1

This male infant was born after 32 weeks gestation; his neonatal course was complicated by mild recurrent apnea. At the time of the infant's discharge from the hospital, the parents were instructed in cardiopulmonary resuscitation. The infant was not given theophylline or started on a home monitor program. At 6 weeks of age, the mother noted that after a feeding he was pale, limp, and apneic while asleep. CPR was required for 20 seconds before spontaneous breathing was resumed. Hospital studies included a sleep pneumogram, chest x-ray, CBC, blood culture, urinalysis, EKG, EEG, and barium swallow. The EEG showed some abnormal right

temporal sharp activity and voltage slowing. His pneumogram lasted 18 hours, and he had 2 episodes of central apnea of 10-14 seconds duration, one with bradycardia to less than 80 beats per minute and four episodes of obstructive apnea 10-14 seconds duration, one with bradycardia. Periodic breathing accounted for 9.8% of the total study (normal < 5%). The baby was enrolled in the home monitor program and discharged. Sleep pneumogram studies at 4 months and 7½ months were normal, however the home monitor program was continued because of a history of recurrent apneic alarms as recorded by the mother in her daily log. A pneumogram at 11 months of age was abnormal due to four episodes of apnea 10-14 seconds duration and one of 15-19 seconds, all but one associated with bradycardia.

The infant required vigorous stimulation for an apneic and bradycardic event at 12 months of age. Follow-up studies at 14 months of age have been normal, and he was taken off the monitor at 18 months of age.

Case 2

This 1.56 kg. male infant was born to a 32-year-old gravida 2 para 1 mother by spontaneous vaginal delivery under epidural anesthesia at 28 weeks gestation. The Apgar scores were 5 and 6. The infant initially had transient tachypnea that cleared by 1 day after birth. At 2 days, the infant experienced recurring apnea and bradycardia with cyanosis, and he frequently required cutaneous stimulation to resume normal breathing. Theophylline therapy was initiated, and these episodes decreased in number and intensity. Metabolic, pulmonary, and cardiovascular studies were all negative, as was a septic work up. The theophylline was discontinued at 2 weeks of age, and he was tested for sleep apnea prior to his discharge at 5 weeks of age.

Over a 12-hour period, there were two episodes of prolonged apnea of greater than 24 seconds, both associated with bradycardia. There were four prolonged apneic episodes lasting 15-19 seconds and nine episodes lasting 10-14 seconds. He was enrolled in the home monitor program and discharged; he was not on theophylline at that time.

After 9 days at home, the infant had a spell of apnea and bradycardia requiring vigorous stimulation. Two days later he was readmitted to the hospital with recurrent prolonged apnea and pneumonia. Respiratory syncitial virus grew in culture, and he required ventilatory assistance for 8 days. Theophylline therapy was begun and maintained at discharge after 18 days. Although readmission was not necessary, the infant subsequently had episodes of apnea greater than 20 seconds duration requiring some form of tactile stimulation for resumption of normal breathing. Follow-up pneumograms at 6 months and 9 months of age were normal. Theophylline was discontinued at 6 months of age, and the infant was discharged from the home monitor program after the second normal pneumogram.

Case 3

This 4.2 kg. male infant was born to a 32-year-old gravida 6 para 5 mother by elective low forceps delivery under epidural anesthesia at 41½ weeks gestation. Apgar scores were 9 at 1 and 5 minutes. The pregnancy, labor, and delivery were uncomplicated. This couple's fourth child died at age 3 months of suspected SIDS, but an autopsy was not done. The parents requested that this most recently born infant be tested for the presence of prolonged sleep apnea. When he was 3 days old, he was monitored in the hospital for prolonged apnea for 16 hours (usual test period, 12 hours). There was one episode of central apnea lasting 10 seconds; there was no periodic breathing. Although the study was negative, the baby was enrolled in the home monitor program at the request of the parents. Follow-up impedance pneumography and cardiotachography at 4 months of age was normal. The infant remained in the program for 10 months. There were no episodes of apnea requiring stimulation.

The Home Monitoring Program

It is important to emphasize that a monitor is used as part of a complete program of home care. After a home monitor is ordered, referral is made to the R.N. administering the home monitoring program. This nurse works with the parents to secure insurance or Medicaid coverage if appropriate. For those patients without third party coverage, partial payment by the parents may be supplemented by charitable organizations. The parents are instructed by the nurse in infant CPR technique, the local emergency rescue team and power company are alerted to the special needs of the patient and family, and printed forms are given to the parents with instructions to maintain a daily log of all alarms and resuscitation events. The logs are mailed to the nurse weekly.

The parents are instructed in detail in the use and maintenance of the monitor by a representative of the proprietary monitoring company (Healthex Corp., Marietta, Georgia). This includes information packets and 3-5 hours of onsite instruction. Contact with the company for purposes of securing supplies (electrodes, monitoring belts, wires), maintenance, and follow-up testing is done through the home monitoring program nurse.

The nurse makes one home visit at the beginning of the program and then maintains weekly telephone contact. The physician advisor to the home monitoring program conducts monthly evaluation conferences with the nurse to review all cases and deter-

mine appropriate monitor settings and follow-up testing intervals. However, the primary physician contact is through the family practitioner or pediatrician. Problems related to the monitor and questions about recurrent apneic spells are handled initially by the home monitoring program nurse or physician, and referral may then be made to the physician advisor to the program.

There are several factors to consider before discontinuing the home monitoring program. The infant should have experienced an interval of 2 months since the last apneic episode requiring resuscitation or stimulation, and there should be at least one normal pneumogram if the infant is 9 months or older or two normal pneumograms if the infant is less than 9 months old. It is helpful to know whether the infant had a URI or DPT in the preceding 2 months with no apneic events. The history of the initial apneic event, parental perceptions of the importance of the monitor, and environmental factors are also considered.

Studies have shown that infants who had prolonged apneic events requiring resuscitation had a decreased ventilatory response to inhaled CO_2 and higher resting alveolar levels of CO_2 compared to controls.

This program has successfully filled our community need to monitor high-risk intensive care nursery survivors, siblings of previous SIDS patients, and infants who were previously thought to be well but who have experienced prolonged apneic spells requiring resuscitation at home. The program has met with acceptance by parents, and the majority of parents who have lost infants to SIDS or who have had to resuscitate an infant report a reduction in anxiety with use of the monitor. The program is extremely well accepted by parents of very small infants (<1250 grams) who have graduated from the intensive care nursery and have undergone monitoring prior to discharge. The program is expensive, and to date there are no data as to its cost effectiveness in preventing SIDS deaths.

The program is a community oriented project concerned primarily with providing a service to patients. It is not directly funded through government agencies and has proved to be self sustaining through funds provided by patients, third party carriers, and donations of time and money from physician and lay volunteers. Many aspects of this program have been patterned after the research and service oriented programs at Massachusetts General Hospital; however, there are also some unique aspects to this program that may serve as a model for other communities.

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The author describes a method of cerebral revascularization for patients manifesting cerebral ischemic symptomatology with an "inaccessible" vascular lesion.

Microsurgical Cerebral Revascularization: The Extracranial-Intracranial Bypass for Stroke Prevention

ALAN S. FLEISCHER, M.D., *Atlanta**

STROKE IS A MAJOR health care problem, remaining the most costly single disease in the United States. Each year more than 450,000 persons suffer strokes; ⅓ of these patients die, ⅓ suffer disability, and ⅓ return to independent function.[1] Stroke remains the third leading cause of death after heart disease and cancer, and it is estimated that today there are over 2 million people in this country who are disabled secondary to stroke, with the majority of these in their most productive years. Contrary to popular opinion, this disease is not limited to the elderly. Approximately two-thirds occur in persons under the age of 65, and half of these occur in those under the age of 55.[2]

This paper will discuss ischemic stroke which comprises approximately 80% of the total, the remainder being hemorrhagic in etiology due to ruptured aneurysms, arteriovenous malformations, hypertension, etc.[2] Fortunately, a large percentage of ischemic strokes are preceded by so-called "warning signs." Therefore, this makes the most meaningful treatment for ischemic stroke prophylaxis. Five to 60% of patients with transient ischemic attacks (TIA) will have a completed stroke within one year and up to 75% within three years. The mortality rate in TIA patients with stroke is 5% in the first year and 21% within 4 years. The mortality rate in the prolonged reversible neurologic deficit (PRND) group of patients over a 4-year period ranges from 17% to 40%, while up to 55% deteriorate neurologically during the same period. Ischemic stroke itself, or completed stroke (CS), is perhaps the most dramatic of all warning signs, with 29 to 40% of patients with CS succumbing within 3 years from another stroke.[3]

Fortunately for those patients who heed the warning signs, early treatment of vascular problems can avoid the increased risk of stroke. The majority of these patients, approximately 65%, are found to have large vessel disease, half of which is due to carotid bifurcation narrowing and/or ulceration which is directly accessible for surgical correction.[3] The remainder of these patients subject to ischemic stroke, approximately 30 to 35%, have what are considered to be "inaccessible lesions."[4] Inaccessible cerebrovascular lesions include arterial stenosis or occlusion above an imaginary line joining the ramus of the mandible to the mastoid process. Inaccessible lesions beyond the reach of the neurosurgeon or the vascular surgeon in terms of direct repair therefore consist of internal carotid artery occlusion either extracranially or intracranially, intracranial internal carotid artery stenosis, middle cerebral artery stenosis, and middle cerebral artery occlusion (Table 1). Similar problems may occur with the vertebrobasilar circulation; however, this communication is limited to the cerebral circulation. The purpose of this paper is to describe a method of cerebral revascularization for patients manifesting

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TABLE 1 — Inaccessible Lesions

Internal carotid artery occlusion
A) Extracranial
B) Intracranial
Intracranial internal carotid artery stenosis
Middle cerebral artery stenosis
Middle cerebral artery occlusion

cerebral ischemic symptomatology with an inaccessible vascular lesion. This operative therapy, first performed in 1969, is designated an extracranial-intracranial bypass procedure (EC-IC bypass).

Stroke Terminology

Hemispheric transient ischemic attacks (TIAs) are episodes which produce a distinct neurologic deficit such as an hemiparesis, paresthesia, or dysphasia which clears in a matter of minutes or hours. The attack must be less than 24 hours in duration, and the patient must return to his pre-symptomatic state for the episode to be so defined. In monocular (Amaurosis fugax) episodes the patient has a transient loss of vision in one eye, often described as being like a "window blind" being pulled over the eye from above, which then gradually recedes. Vertebral transient ischemic attacks (TIAs) are episodes similar to those described above except that the symptoms include vertigo, diplopia, dysarthria, and bilateral or alternating paresis or paresthesia. The isolated occurrence or recurrence of vertigo, diplopia, amnesic episodes, drop attacks, or loss of consciousness is not accepted as evidence of vertebral-basilar disease.

A prolonged reversible neurologic deficit (PRND) is an episode which produces a neurologic deficit such as is described for TIAs which lasts longer than 24 hours but is followed by a return to the normal state.

A completed stroke (CS) is a definitive neurologic deficit which becomes static.

Patients and Methods

From November, 1974, to January, 1981, 175 EC-IC bypass procedures on 151 patients were performed at Emory University Hospital, Atlanta, Georgia, by the author. The average age of the patient undergoing surgery in this series was 59 years; 71% of the patients were men, 29% were women. The indications for EC-IC bypass procedure in this group included 101 patients with internal carotid artery occlusion either extra- or intracranially. Twenty-four of these patients with internal carotid artery occlusion had bilateral occlusion and underwent bilateral EC-IC bypass procedures. Twenty patients presented with stenosis of the intracranial internal carotid artery, 16 presented with middle cerebral artery stenosis, and eight presented with middle cerebral artery occlusion. An additional six patients underwent EC-IC bypass procedures prior to repair of a giant middle cerebral artery aneurysm or the treatment of Moya-Moya disease.

Treatment

To increase cerebral blood flow and to eliminate a source of emboli, accessible carotid bifurcation lesions have been approached operatively since the early 1950s. However, it was not until 1967 that a surgical procedure was developed for approaching "inaccessible" lesions. The foundation for such a procedure had been laid by Jacobson and Suarez[6] who, using the operating microscope and microinstruments available in the early 1960s, were able to anastomose one and two mm vessels which remained patent. In 1967, Yasargil, working in Donaghy's laboratory applied these techniques to the problem of cerebral revascularization by demonstrating the feasibility of anastomosing the superficial temporal artery (STA), an external carotid artery branch, to the cortical middle cerebral artery in the dog. One year later, Yasargil performed an EC-IC bypass procedure for a patient with hemispheric ischemia secondary to an occluded internal carotid artery.[5] In the past decade, over 2,000 such procedures have been performed for patients with these previously inaccessible vascular problems. Patients presenting with symptoms and signs of cerebral ischemia are evaluated with cerebral angiography. The finding of any of the previously mentioned inaccessible lesions makes the patient a candidate for the EC-IC bypass procedure.

Although the occipital artery may be used for the EC-IC bypass procedure,[7] the STA is by far the most common extracranial vessel used for this procedure. The technique used at Emory from 1974 to 1981 is basically the same as that described by Yasargil, with some modification. By referring to the angiogram and palpating the scalp, an STA branch is identified, preferably the posterior branch, and microsurgically dissected from its vascular bed from the underside of a scalp flap created by making a linear incision ending in a hockey stick shape (Figures 1 and 2). This is designed to include the area approximately 6 cm above the external auditory canal where the terminal branches of the middle cerebral artery that come to the cortical surface are mostly likely to be larger than 1 mm in diameter. A craniectomy approximately 2 cm in diameter is created to expose the area of the angular gyrus (Figure 1), the dura mater is opened in a cruciate fashion (Figure 3), and a 10 mm segment of an appropriate recipient cortical vessel is freed from the arachnoid (Figure 4). This work is performed meticulously under magnification of 10 to 25×, with bipolar

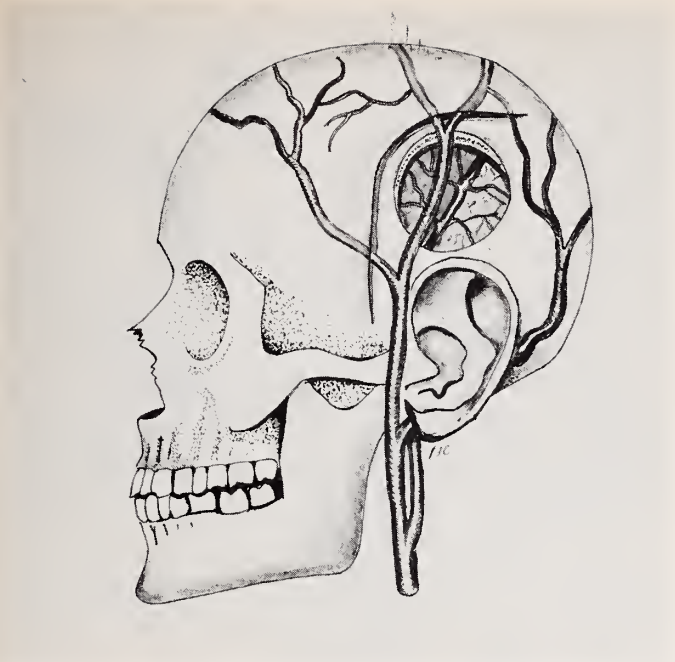


Figure 1 — The anatomy involved in the STAMCA anastomosis. The hockey stick shaped incision is outlined on the scalp. Shown also are the posterior branch of the STA, the craniectomy site, and the recipient cortical middle cerebral artery.

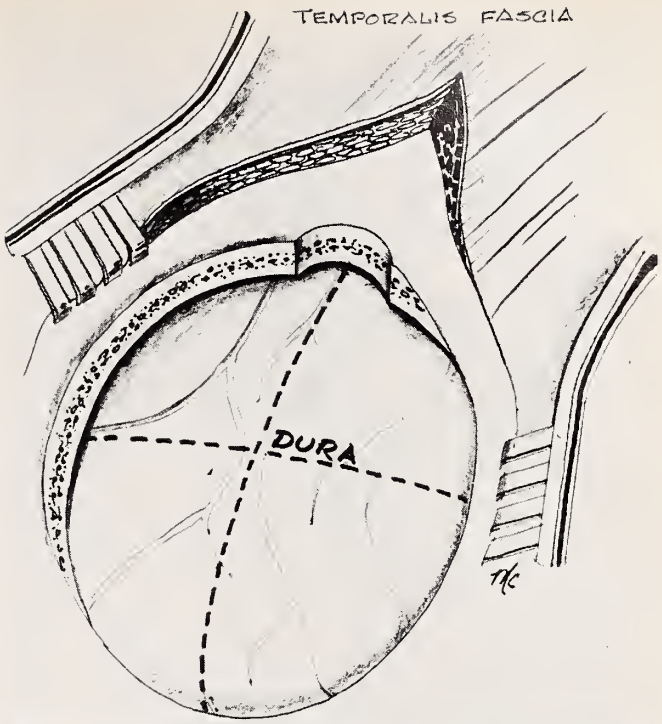


Figure 3 — Following division of the temporalis muscle, a craniectomy as depicted is performed and the dura opened in cruciate manner.

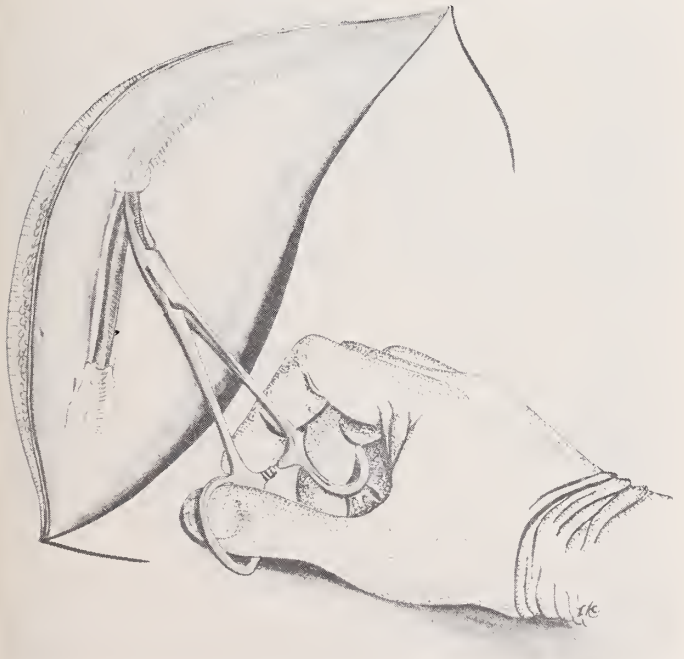


Figure 2 — Microscopic dissection of the posterior branch of the superficial temporal artery from the undersurface of the scalp flap.

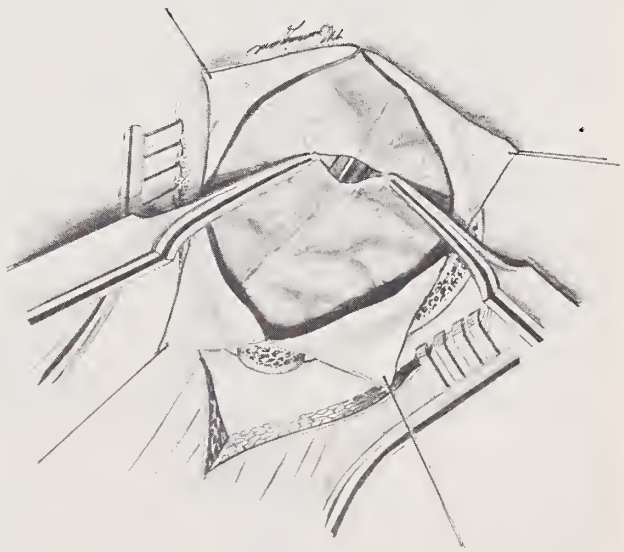


Figure 4 — Microsurgical dissection of arachnoid from the cortical middle cerebral artery branch which will be the recipient vessel of the anastomosis.

coagulation and microinstruments. The distal centimeter of the donor vessel is freed of adventitia (Figure 5), and its end is cut obliquely and fish mouthed (Figure 6). The cortical vessel is then isolated and a small square of silastic material placed beneath it to protect the underlying brain. Temporary clips are applied to the proximal STA and to the recipient cortical middle cerebral artery branch. It is important that the clips have low closing pressure so as to reduce the damage to the intima of these vessels. An arteriotomy is then made in the recipient vessel approximately two to three times the diameter of the donor vessel (Figure 7). The anastomosis is performed with approximately 16 to 18 interrupted 10-0 nylon sutures (Figure 8 and 9). Once flow is established and hemostasis assured, the craniectomy site is covered with gelfoam and the temporalis muscle closed with care so as not to occlude the donor vessel (Figure 10). The scalp is then closed in the usual fashion. The completed STA-MCA anastomosis is depicted in Figure 11 and 12.

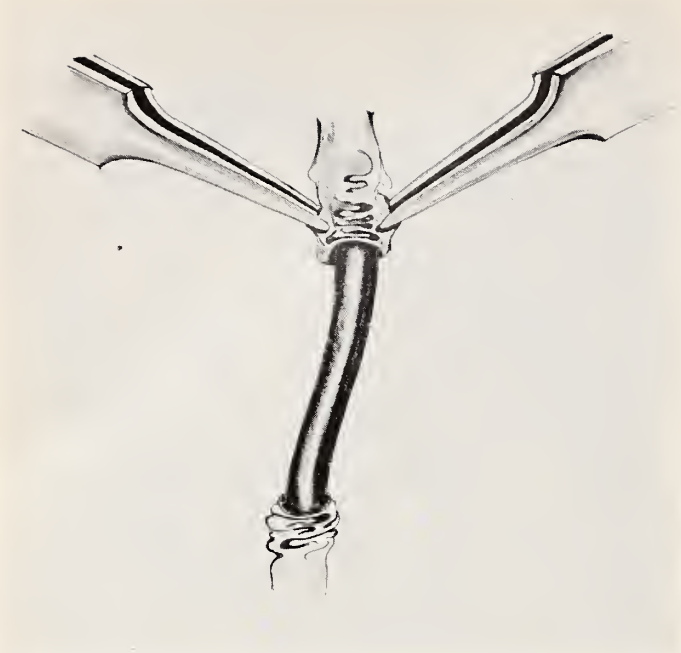


Figure 5 — Illustration of technique for removing adventitia tissue on the distal centimeter of the donor vessel.

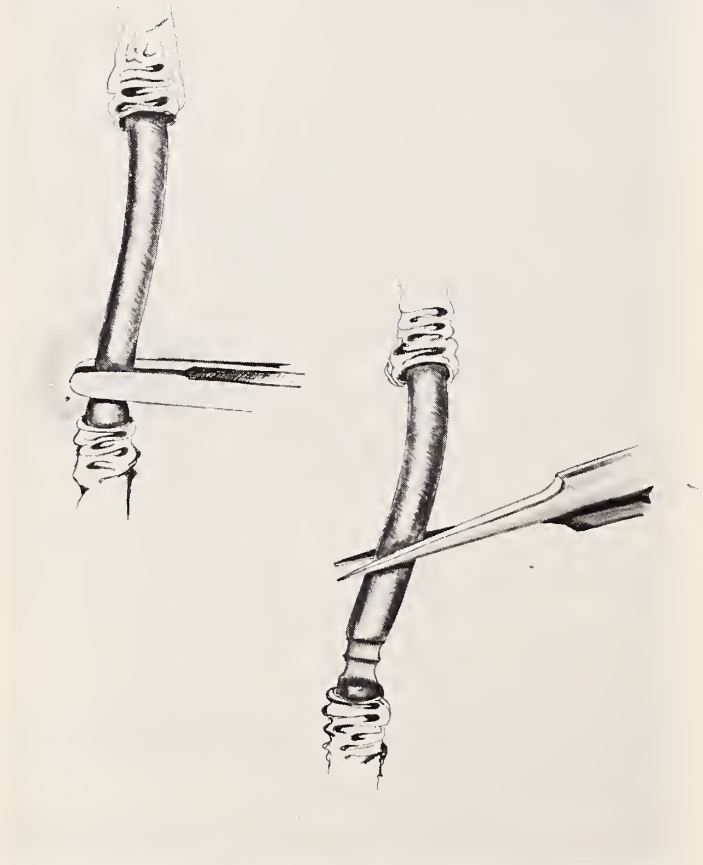


Figure 6 — After bipolaring the distal end of the superficial temporal artery (donor vessel), a proximal temporary clip is applied and the vessel divided obliquely.

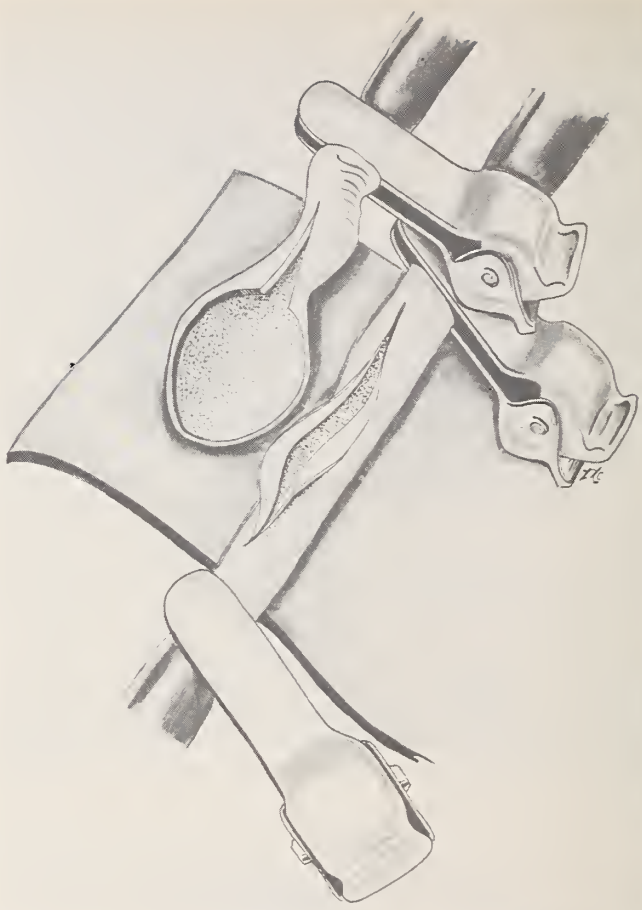


Figure 7 — At approximately 25 power magnification, this illustration depicts temporary clips in place on the donor vessel which has been divided obliquely and fish mouthed as well as on the recipient vessel on which an arteriotomy is performed. Note the silastic square protecting the brain surface beneath the anastomosis.

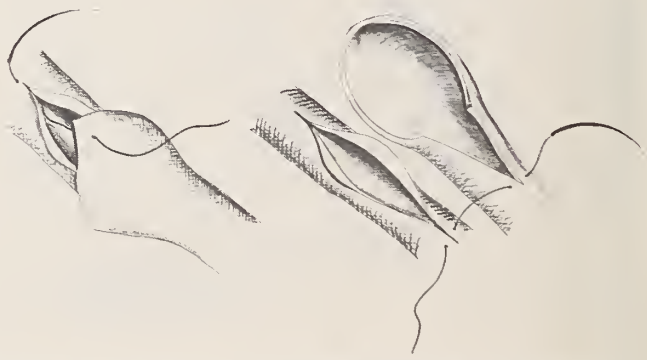


Figure 8 — High-power magnification of the placement of the polar sutures of 10-0 nylon in the initial phase of performing the anastomosis.

A number of variations of this procedure have evolved in order to meet different anatomic situations. When the STA is too small (less than 1 mm diameter), the occipital artery may be used as the donor vessel. The occipital artery has also been used to deliver flow directly to the vertebrobasilar circulation via anastomosis with the posterior inferior cerebellar artery.[8] When no satisfactory extracranial vessel has been available, veins, segments of radial artery, and most recently synthetic expanded polytetrafluroethylene (GORE-TEX*) have been used.[9, 10]

* GORE-TEX, W. L. Gore and Associate, Flagstaff, AZ.



Figure 9 — Placement of the remainder of the sutures and the completion of the microvascular anastomosis.



Figure 10 — The technique used to close a temporalis muscle in which an incision is made so as to avoid compression of the superficial temporal artery.

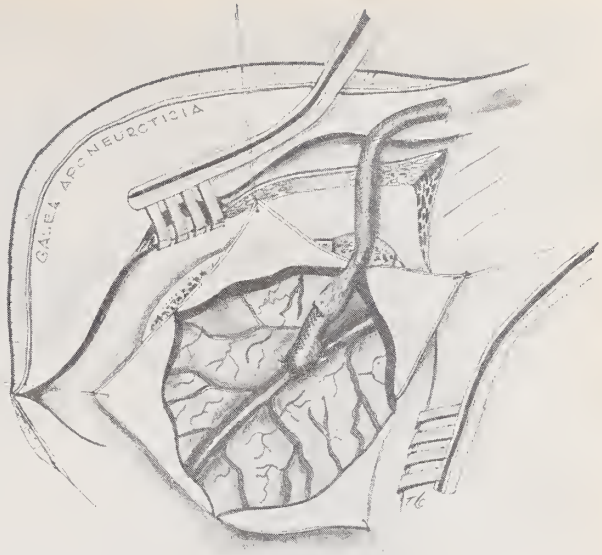


Figure 11 — Low-power magnification (approximately 10×) of the completed STAMCA anastomosis.

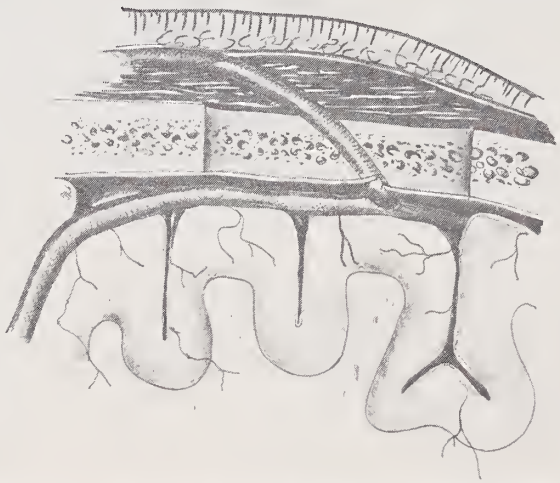


Figure 12 — Side view of the completed anastomosis.

Because cross clamping of the cortical vessel does cause an area of decreased cerebral blood flow, the duration of clamping should be minimal. Chater and Popp[11] have associated occluding the vessel for longer than 30 minutes with an increased incidence of minor neurologic defects which, fortunately, have usually cleared spontaneously. It is apparent that the surgical team involved in this procedure must be highly trained in order to keep the clamping time to a minimum and the chance of graft patency to the maximum.

Results

The recent review by Sampson and Boone[12] of the major series of cerebrovascular surgery results to date is encouraging. It demonstrates a marked lessening in the recurrence of TIAs following EC-IC bypass operations (85% to 95% of patients were free of TIAs, and in 5% to 8% the attacks occurred with markedly reduced frequency). Most important, the incidence of stroke has also been markedly reduced in these patients: only 3% to 4% of patients undergoing this procedure suffered strokes in the months following this procedure. In addition, the incidence of strokes in the group of patients with minor strokes and documented decreased cerebral perfusion has been markedly reduced. In this group, as many as 67% of unoperated patients have had a second stroke within 24 months of a first, minor stroke. When such patients received a bypass procedure, the stroke rate dropped to less than 2%. It is still questionable whether this procedure can improve the quality of function after even a minor stroke, however. The

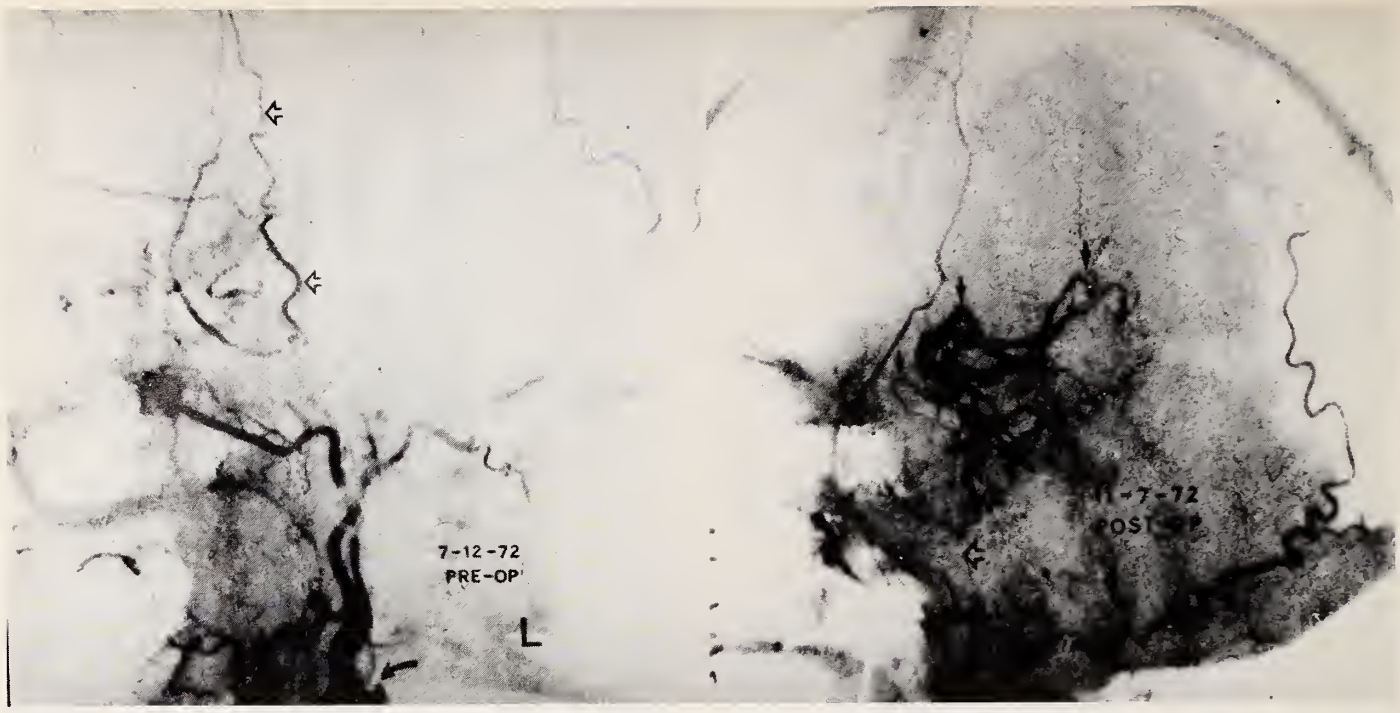


Figure 13 — (A) Preoperative left carotid arteriogram demonstrating occlusion of the internal carotid artery at the bifurcation of the common carotid artery (curved dark arrow). This also demonstrates the STA (open arrows). (B) Postoperative (STAMCA anastomosis) angiogram depicting the STA (open arrows) filling the MCA (closed arrows) in one of the author's earliest cases.

results in the Emory series of 175 consecutive EC-IC bypass procedures are as follows. Two deaths occurred, one secondary to a hypertensive intracerebral hemorrhage occurring intraoperatively or immediately postoperatively and the second to a major hemispheric infarction. The morbidity includes one acute subdural hematoma and one subacute subdural hematoma, both of which were evacuated with no sequelae. There were two superficial infections which were successfully treated. Eighteen patients experienced transient minimal neurologic worsening; however, all returned to their preoperative state or improved. Angiographic patency rate is 95% (Figure 13), and one angiographically demonstrated pseudoaneurysm[13] spontaneously regressed over a period of 1 year to a normal-appearing anastomosis. The overall incidence of infarction in patients followed from 1974 through 1981 was 4%, which is considerably less than expected without the EC-IC bypass procedure.

Conclusion

Although the initial results of EC-IC bypass procedures are very encouraging, they are retrospective in nature. In order to establish a scientific value for this procedure, an international collaborative study has been initiated under the direction of Henry J. Barnett, M.D., at the University of Western Ontario (under the support of the United States National Institute of Neurological and Communicative Disorders and Stroke).[14] The specific objective of this study is to conclude whether "extracranial-intracranial bypass grafting will reduce by 50% or more the incidence of first or recurrent complicated strokes in patients with certain forms of cerebrovascular disease." The study is randomized with a strict protocol which includes obligatory follow-up of all patients for 5 years. Thus far, over 1,000 patients have been entered in the study in which Emory is participating.

Meanwhile, it appears from preliminary studies of others[15, 16] and the Emory experience that surgical intervention by well-trained teams of microvascular surgeons can benefit many of those patients who have transient focal ischemia or who have suffered a mild CS from lesions in previously "inaccessible" locations.

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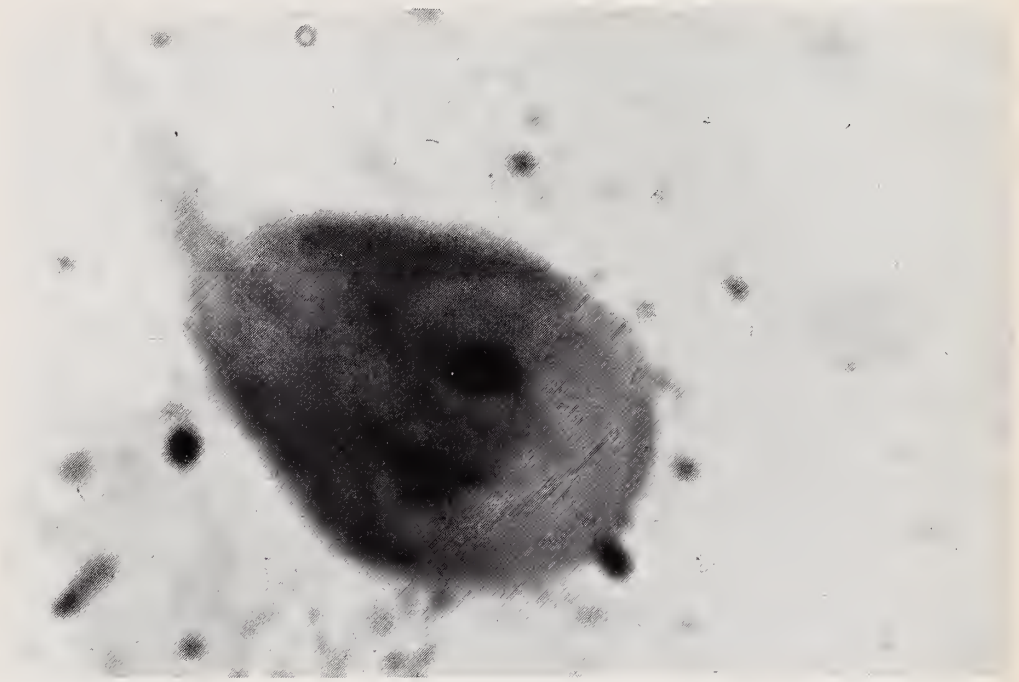
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include Giardia lamblia (motile trophozoites), Strongyloides stercoralis (larvae and/or eggs in advanced stages of development), Clonorchis sinensis (eggs), Fasciola hepatica (eggs), Trichostrongylus orientalis (eggs), and Isospora (coccidia).

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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG.

CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (*i.e.*, that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, *e.g.*, isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis; erythematous rash; fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis; nonthrombocytopenic purpura; thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease; elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DOSAGE AND ADMINISTRATION

ORAL

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, *e.g.*, LEVARTERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

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INDERAL (propranolol hydrochloride)

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No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as: 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981

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A Summary of the Proceedings of the MAG's 1982 Annual Session

The first General Session of the 1982 Annual Session of the Medical Association of Georgia was called to order by the President, L. Newton Turk, III, M.D., of Atlanta, at 7:05 p.m. in Ballrooms A and B of the Savannah Hyatt Regency. Dr. Turk introduced the Reverend James E. Rush of the Isle of Hope United Methodist Church who gave the invocation. Reverend William E. Gardner of the Bull Street Baptist Church led the group in the National Anthem and the Pledge of Allegiance to the flag.

Dr. Turk then read the names of the MAG members who had died since the 1981 Annual Session. They were: José G. Alfonso, Valdosta; Rafe Banks, Gainesville; V. H. Bennett, Athens; C. Dewitt Briscoe, Monroe; Don F. Cathcart, Atlanta; Calder B. Clay, Jr., Macon; Marshall Cohen, Atlanta; Morgan A. Cowan, Macon; Zachary S. Cowan, Atlanta; Carlos Duarte, Decatur; W. P. Durham, Abbeville; Paul T. Erickson, Decatur; Earl H. Floyd, Atlanta; A. G. Funderburk, Moultrie; Michel A. Glucksman, Brunswick; Willard R. Golsan, Macon; J. H. Jackson, Barnesville; Lemuel P. James, Macon; O. W. Jenkins, Lindale; D. C. Kelley, Lawrenceville; J. T. King, Thomasville; Herbert F. Laramore, Atlanta; J. W. Lipscomb, Atlanta; William G. Love, Jr., Columbus; Stephen M. McDew, Savannah; F. Earl McLendon, Atlanta; H. G. Mealing, Augusta; J. C. Metts, Sr., Savannah; Albert L. Morris, Fairburn; George J. Pastorius, Savannah; William C. Patton, Chattanooga, TN; W. T. Randolph, Winder; C. A. N. Rankine, Atlanta; W. A. Scoggin, Augusta; E. Faxton Seay, Fort Valley; Howard K. Sessions, Sumner; A. R. Sims, Richland; Trawick H. Stubbs, Atlanta; Jules S. Terry, Atlanta; Albert C. Tuck, Thomasville; Austin J. Walter, Sautee-Nacoochee; George S. Whatley, Columbus; and J. Randall Winburn, Savannah.

At the conclusion of the memorial service, Dr. Turk introduced the Honorable John E. Rousakis, Mayor of the City of Savannah, who extended official greetings to the city. Then Dr. Eloise B. Sherman, Georgia Medical Society president, welcomed to Savannah those attending and participating in MAG's 128th Annual Session.

Dr. Turk introduced Mrs. Perry M. (Katherine) White, President of the Auxiliary to the MAG, who gave a brief report of the activities and accomplishments of the Auxiliary in the past year. She introduced special guests of the Auxiliary, Mrs. Mylie Durham, Jr., AMA Auxiliary Director; Mrs. William D. Hughes, Southern Medical Association (SMA) Auxiliary's President-Elect, and Mrs. Keith D. Jones, the current president of the SMA Auxiliary.

Mrs. A. Frank Isele, AMA-ERF Chairman, and Mrs. White then presented the AMA-ERF checks as follows: to the Medical College of Georgia, a check for $14,608.69; to Emory University School of Medicine, $11,221.86; and to Morehouse School of Medicine, $1,640.88.

Awards

H. Hilt Hammett, Jr., of LaGrange, received the Distinguished Service Award. The Civic Endeavor Award was presented to James A. Kaufmann, of Atlanta. Dr. Lanny R. Copeland presented the Family Physician of the Year Award to H. Gordon Davis of Sylvester.

Certificates of Appreciation

William D. Logan, Jr., Secretary of the MAG, presented Certificates of Appreciation to the following physicians: L. Newton Turk, III, President of the MAG in 1981-82; Charles D. Hollis, Jr., for service as President of MAG Mutual Insurance Company;



Figure 1 — Immediate Past President H. Hilt Hammett, Jr., (left), of LaGrange, was honored with the 1982 Distinguished Service Award and is congratulated by President L. Newton Turk, III, of Atlanta.

Spencer G. Mullins, Chairman of the MAG Disabled Doctors' Committee, 1981-82; C. Daniel Cabaniss, Chairman, MAG Education Committee, 1981-82; Caroline G. Williams, Chairman, MAG's Committee on Medicine and Human Values, 1980-82; Mrs. Perry M. (Katherine) White, President of the Auxiliary to the MAG, 1981-82; William C. Collins, MAG's First Vice-President, 1981-82; Milton Frank, III, Chairman of MAG's Membership Committee; Michel A. Glucksman, Alternate Director, MAG Board of Directors, 1978-81; and Jules S. Terry, for outstanding service to MAG's Maternal and Infant Health Committee, 1974-82.

Fifty-Year Certificates

Fifty-Year Certificates and pins were presented to: Frank Benson, Fort Valley; Lester A. Brown, Atlanta; Leslie M. Buckner, Albany; Amey Chappell, Atlanta; William B. Davis, College Park; Robert B. Greenblatt, Augusta; William K. Jordan, Macon; J. Z. McDaniel, Albany; A. Park McGinty, Atlanta; Charles H. Mitchell, Augusta; Marvin A. Mitchell, Atlanta; William E. Mitchell, Atlanta; Lewis H. Oden, Jr., Blackshear; J. R. Paulk, Moultrie; Thomas F. Sellers, Sr., Atlanta; Cyrus H. Stoner, Atlanta; and Morris B. Taranto, Atlanta.

Life Members

Dr. Turk then announced that the following members had been awarded life membership in the MAG: John A. Bell, Jr., Dublin; William H. Bennett, Atlanta; H. Bagley Benson, Atlanta; Hugh J. Bickerstaff, Columbus; M. B. Bowman, Albany; Isadore R. Cohen, Atlanta; W. W. Coppedge, East Point; James B. Craig, Milledgeville; R. F. Dickinson, Albany; William H. Galvin, Decatur; Irving L. Greenberg, Atlanta; William C. Hathcock, Atlanta;



Figure 2 — James A. Kaufmann (right), of Atlanta, was the 1982 recipient of the Civic Endeavor Award for his dedication to medicine and service to his community. Congratulating him are (left to right) President L. Newton Turk, III, James H. Sullivan, of Columbus, treasurer of the MAG, and Jack A. Raines, also of Columbus, Chairman of the MAG Board of Directors.



Figure 3 — Dr. Kaufmann expresses his gratitude to those at the First General Session of the MAG House of Delegates for the honor of receiving the Civic Endeavor Award. Jack A. Raines (middle) and Jack F. Menendez, of Macon, Speaker of the House, are in the background.

William H. Holden, Nova Scotia; Charles E. Holloway, Atlanta; Charles K. Howard, Atlanta; Richard King, Atlanta; Charles L. Langsam, Atlanta; Ted F. Leigh, Atlanta; Jack M. Levin, Atlanta; R. Bruce Logue, Atlanta; James S. Peters, Jr., Atlanta; Arthur P. Richardson, Atlanta; C. Purcell Roberts, Atlanta; William Rottersman, Atlanta; Charles F. Stone, Jr., Atlanta; Homer S. Swanson, Atlanta; Alexander Szecsey, Roswell; Frank Thomas, Albany; A. G. Thurman, Augusta; John Kirk Train, Savannah; Robert J. Walker, Jr., Macon; Edwin R. Watson, Macon; and John Z. Zirkle, Savannah.

FIRST SESSION — HOUSE OF DELEGATES

The First Session of the MAG House of Delegates was called to order by the Speaker of the House, Jack Menendez, at 8:25 p.m., Thursday, April 22, 1982, in Ballrooms A and B at the Hyatt Regency in Savannah. James A. Kaufmann, of Atlanta, served as Vice-Speaker of the House.

The Speaker called for a report from the Credentials Committee. Dr. Walker Ray reported 143 duly

elected delegates in attendance, representing 41 component medical societies, and accordingly announced that a forum of the House was present. A complete list of those attending is published in the Proceedings Supplement to this issue of the *Journal,* as is a list of all those appointed to specific committees. The Supplement will be mailed to members of the Association on request.

SECOND SESSION — HOUSE OF DELEGATES

The Second Session of the MAG House of Delegates was called to order at 10:00 a.m. on Saturday, April 24, in Ballrooms A and B of the Hyatt Regency in Savannah by Speaker Jack Menendez.

Speaker Menendez introduced Charles D. Hollis, Jr., M.D., MAG's President-Elect, who addressed the House briefly, outlining his programs for the coming year.

Following Dr. Hollis' address, the Speaker asked for a report on attendance from the Credentials Committee, and Dr. A. D. Muse responded that there were 171 duly elected delegates present, representing 41 component county medical societies. Accordingly, a quorum was present. Speaker Menendez then called for reports from the Reference Committee Chairmen.

REFERENCE COMMITTEE REPORTS

Summary of House Actions on the Reference Committee on Constitution and Bylaws

The majority of the topics which mandated action by the 1982 House of Delegates referred to the Reference Committee on Constitution and Bylaws were either items which had "laid on the table" for 1 year (as required for approval of actions specifically pertaining to Constitutional amendments) or items which required action for definitive or interpretative purposes.

Constitutional amendments which had been presented at the 1981 House and subsequently were adopted by the 1982 House are as follows:

Article II — Objectives of the Association

The objectives of the Association are to promote the science and art of medicine and the betterment of public health as provided for in the Bylaws.

Articles VIII and IX — District Societies; Officers

(This is a numerical change only to reflect the appropriate chronologic order of the articles in the Constitution; the present language remains the same.)

Article IX — Officers

The general officers of the Association shall be those that are specified in the Bylaws. Their qualifications and terms of office shall be provided for in the Bylaws. (This amendment does not in any way alter the present officers but is provided only as a means of simplifying the Constitution and Bylaws.)



Figure 4 — (Left) Speaker of the House, Jack F. Menendez, of Macon, and Vice-Speaker of the House, James A. Kaufmann, of Atlanta, contributed their well-learned expertise to effect a smooth progression of the business brought before the House.

The House rejected the 1981 proposal to amend Article VI — Board of Directors, Section I, Composition, and Section 2, Duties.

Items referred to the House regarding Bylaws amendments were acted upon as follows:

Chapter VIII, Section 12 — House Officer Section, was adopted by the House. This addition will allow for earlier involvement by interns, residents, and fellows into organized medicine.

Chapter II, Section 5 — Affiliate Members, was repealed.

The clarification amendment to *Chapter II, Section I, Subsection (e), Dues Exempt Members,* was adopted. This will provide definition within the subsection and gives all members in the DE-I category all rights and privileges of regular dues paying, active members.

Adoption of the addition of a new subsection to *Chapter II, Section I, to be the new Subsection (f),* provides for those physician members who have reached the end of the sliding dues scale and are dues exempt, over 70 years of age, and gives DE-7 members all rights and privileges as active members.

Adoption of the amendment to *Chapter IV, Section 2, Delegate Apportionment,* was an action of clarification which allows for delegate entitlement to the MAG House by its component societies to count only those physicians within a county medical society who are actual members of the society on 12/31 of each year.

The comprehensive legal review of the Bylaws was adopted as presented. Items of this revision represent primarily editorial changes and changes to clarify interpretation.

Resolutions 8 and 17, which were considered together, concerning specialty society representation and representatives, were referred to the MAG



Figure 5 — President L. Newton Turk, III, addressed the Auxiliary to the MAG, thanking the members for their dedicated service toward achieving the common goals of the Auxiliary and the MAG.

Board of Directors for committee study and subsequent report to the Board with its recommendations, as this topic was found to be highly controversial. It was also indicated that sufficient information was not available on which to base a knowledgeable recommendation.

Resolution 15, which concerns physicians newly entering practice becoming members automatically for 6 months, was adopted. It was also referred to the Board of Directors for further investigation.

New Business — Delegate F. William Dowda introduced a proposed constitutional amendment to lay on the table until the 1983 Session of the House of Delegates, at which time this amendment would be up for a vote before the House. The Amendment is as follows: Article 5, Section 1: by adding between the words "Societies" and "as" the following: the House Officer Section and Accredited Georgia Medical Schools" so that the first sentence of Article 5, Section 1, shall read as follows: "The House of Delegates is composed of Delegates elected by the Component County Medical Societies, the House Officer Section, and Accredited Georgia Medical Schools as provided in the Bylaws."

Summary of House Actions on Reference Committee A

Reference Committee A studied five reports and two resolutions. The Report of the President outlined the achievements of the Association during the term of L. Newton Turk, III, M.D., of Atlanta. Dr. Turk recommended that MAG participate in the organization of a statewide coalition of medicine, business, hospital, labor, and insuror organizations to pursue health care cost containment. The House agreed that MAG should become involved in such a statewide coalition and "stands ready through the Voluntary Effort to offer assistance to such groups in the attempts to control the rising costs of medical/health care, and further we encourage component County Medical Societies to support and foster formations of similar local and regional coalitions."

The House did not go along with the President's recommendation that MAG establish an in-house legal department along with a law library. The House felt that the current arrangement with outside legal counsel is satisfactory.

In considering the Access to Health Care Committee's Report, the House agreed that the Medical Fair and Pre-Practice Seminars be continued. These meetings attempt to get together physicians looking for a place to practice and rural communities looking for doctors.



Figure 6 — (Left) Barbara Thibodeaux (Mrs. David C.), of Marietta, is the incoming Auxiliary President for 1982-83. Katherine White (Mrs. Perry C.), of Atlanta, served as President in 1981-82.



Figure 7 — Addressing the House from his microphone again is delegate F. William Dowda, of Atlanta. Louis Sullivan (left), Dean and President of the Morehouse School of Medicine, and Milton I. Johnson, Jr., of Macon, a former MAG President, wait their turn to express their views.



Figure 8 — Seated left to right are MAG delegates Henry A. Foster, of Griffin; James M. Skinner, also of Griffin; Hugh O. Hodges, of Winder; S. William Clark, Jr., of Waycross; and Joe L. Nettles, the new Director of the Georgia Medical Society in Savannah.

The Physician-Lawyer Liaison Committee reported on problems between the State Bar and MAG in agreeing on a set of "Principles Governing Physician-Attorney Relationships." The House directed that the State Bar be contacted expressing distaste and displeasure over the situation and urged the Committee to work toward resolving the differences.

The House commended the Risk Management Committee for the seminars the committee conducted in the efforts to get physicians' liability premiums reduced and asked for a continuance of the seminars.

Dr. Emory Bohler, chairman of the Ad Hoc Bohler Committee, asked that the committee be disbanded, as its work had been completed. The House agreed, and the committee was disbanded. The committee was commended for its diligence in completing its tasks in a most satisfactory manner.

Dr. William Dowda, a delegate from the Medical Association of Atlanta, introduced two resolutions which were referred to Reference Committee A. The first concerned the excessive violence and sex which appears on television. The House agreed to express its distaste for the expressions of the excessive use of violence and sex on TV and asked each MAG physician member to work with appropriate groups of his or her choosing to better the situation.

Dr. Dowda's second resolution concerned unified membership with the AMA. The House encouraged all MAG members to belong to the AMA but only on a strictly voluntary basis.

Reference Committee A was chaired by Charles W. McDowell, Jr., M.D., of Decatur, the Vice-Chairman was Carl V. Hancock, Jr., M.D., of Albany. Mr. Ken Williams was the MAG staff person assigned to the committee.

Summary of House Actions on Reference Committee B

On the basis of recommendations made by Reference Committee B, the 1982 House of Delegates commended the MAG Cost Awareness Committee for its compilation of all past and present MAG suggestions for medical care cost awareness; approved MAG sponsorship/cosponsorship of a Georgia conference on hospital-medical staff relations; adopted a resolution recognizing the merit of antismoking policies in hospitals and discouraging the use of cigarettes and other smoking materials on hospital premises; and recommended that hospital-medical staff bylaws not include a separate category, but include definitions of specified professional personnel, and clearly indicate that they should work under direct supervision of physicians who are members of the medical staff.

The House approved the concept of a statewide voluntary program to help control drug abuse; voted to urge the Department of Medical Assistance to hold public hearings to inform the public of any plans to exercise its option to waive Freedom of Choice requirements in the Medicaid law; approved continuing education of physicians in the importance of records documentation in office and hospital files;



Figure 9 — Jack F. Menendez, Speaker of the House, was diligent in his efforts to facilitate the business brought before the House.

agreed to advise physicians that patients' unresolved problems relating to insurance companies' delay in payment for medical care may be addressed by filing complaints to the Insurance Commissioner; and agreed to encourage and cooperate with Medicare and Medicaid in developing workshops for physicians' office staffs.

In further action, the House of Delegates approved development of an educational brochure on Health Maintenance Organizations and gave the Board of Directors authority to determine if the MAG should apply for the National Cancer Institute SEER contract.

Summary of House Actions on Reference Committee C

Reference Committee C considered three committee reports and ten resolutions. The Cancer Committee report brought attention to the fact that the Division of Cancer Control under the Department of Human Resources has insufficient funds. This results in the inability to treat all eligible patients. The House of Delegates supported the Committee's recommendation to assist in securing adequate funding for this program. This committee was concerned with the proliferation of cancer treatment modalities which had not been tested or approved. The House approved of this Reference Committee's action not to abandon accepted methods of treating cancer until other methods are tested, researched, and accepted.

The Legislative Committee report detailed the number and variety of medical issues brought before the Georgia General Assembly. This Committee continued to stress the importance of the Physician Involvement Program and the need for all MAG members to participate.



Figure 10 — Edmund M. (''Mac'') Molnar (left), of Columbus, and Rupert H. Bramblett, of Cumming, were delegates to this year's Annual Session.

The Medicine and Human Values Committee report outlined the concept of the hospice program which the House approved. Resolution 13 also pertained to hospice. The House rejected this committee's recommendation to alter the MAG position of the ''Living Will.''

Resolution 2 concerns the IRS ruling which objected to physicians deducting a vehicle as an office expense. This was referred to the MAG delegation to the AMA for evaluation and consideration of the feasibility of requesting AMA action. Resolution 3 (adopted by House) supports the elimination of the *nolo contendere* plea and the mandatory suspension of license for the first offense of DUI. Resolution 6 (referred to Board) sets a maximum limitation for awards for pain and suffering. Resolution 7 (referred to Board) regards the discrepancy between what degree an individual has as compared to the designation on his license to practice medicine in Georgia. Resolution 18 (referred to Board) supports the repeal of the minimum number of three for the provider panel for workers' compensation patients. Resolution 20 (adopted by House) is a restatement of the MAG regarding the repeal of the Federal Health Planning Program. Resolution 23 (adopted by House) restates MAG policy to support legislation to repeal Health Systems Agencies. Resolutions 24 and 25 (adopted by House) restate the MAG Board of Directors' policy to support legislation to amend the Federal Trade Commission Act to alleviate the harassment by the FTC of association activities.

Summary of House Actions on Reference Committee D

Reference Committee D offered recommendations on three committee reports and four resolutions. The House filed the report of the Georgia Medical Care Foundation and approved with only minor changes the four recommendations contained in the report of the Nutrition Committee. The House approved two recommendations which Reference Committee D added to the report of the Committee on Physicians' Assistants: 1) that the MAG reiterate

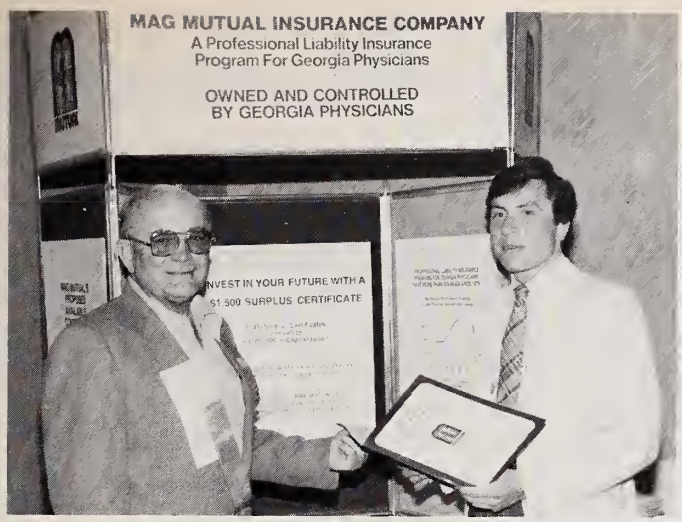


Figure 11 — MAG delegate David A. Wells, of Dalton (left) and Mr. Bert Franco, Executive Vice-President — Marketing for MAG Mutual Insurance Company (and a former MAG staff person) look over the Prospectus for the new professional liability insurance company.

its position (adopted in 1980) that further training and certification of PAs cease until a need for them can be demonstrated; and 2) that the Committee continue to monitor the activities of physicians' assistants in Georgia.

The House adopted resolutions supporting multiple levels of nursing education, particularly those which feature bedside teaching, and requested that a similar resolution be introduced at the AMA House of Delegates. The House also adopted a resolution affirming opposition to unwarranted federal intrusion into the practice of medicine in such matters as PSRO and affirming support of peer review when administered locally by physicians.



Figure 12 — Savannah — Home port of tall ships and the familiar *Barba Negra*. Once an active trading vessel, the *Barba Negra* is used now to collect data for oceanography studies.

The House further adopted a resolution calling upon the MAG Board of Directors to support financially one medical student, preferably a junior or senior, from each of the state's accredited medical schools, to attend the annual and interim meetings of the AMA House of Delegates and the MAG House of Delegates. Finally, the House adopted a resolution commending Robert B. Copeland, M.D., of Troup County, for his services to medicine.

Summary of House Actions on Reference Committee F

Reference Committee F had two items of great interest, generating good attendance and a stimulating debate. First was the Prison Health Care Committee, which MAG had funded for 1 year after Law Enforcement Assistance Administration had terminated. The House agreed with the Reference Committee *not* to fund this program for another year, but to work in an advisory capacity to draft legislation for the establishment of an accreditation program on health care for Georgia correctional facilities and funding of this program.

Second, the additional financial support for the continuing development of MAG Mutual Insurance Company was discussed. The House agreed with the Reference Committee to support MAG Mutual with an additional $100,000, with the charge that MAG seek reimbursement plus interest at such time as MAG Mutual is financially and legally able to repay all fund advances made to them by the MAG.

The other major issue was the 1982-83 budget, amounting to $1,795,919. This budget has a projected expense-over-income of $304,861, but will not require a dues increase from the annual $225 which was effected in 1977-1978.

FINAL GENERAL SESSION

President L. Newton Turk, III, convened the Final Session of the 1982 Annual Business Meeting at 3:37 p.m. in Ballrooms A and B at the Hyatt Regency in Savannah.

Installation of Officers

President Turk installed the following elected officers:

President — Charles D. Hollis, Jr., Albany
President-Elect — Wm. W. Moore, Jr., Atlanta
Second Vice-President — Eloise B. Sherman, Savannah
AMA Delegate — F. William Dowda, Atlanta

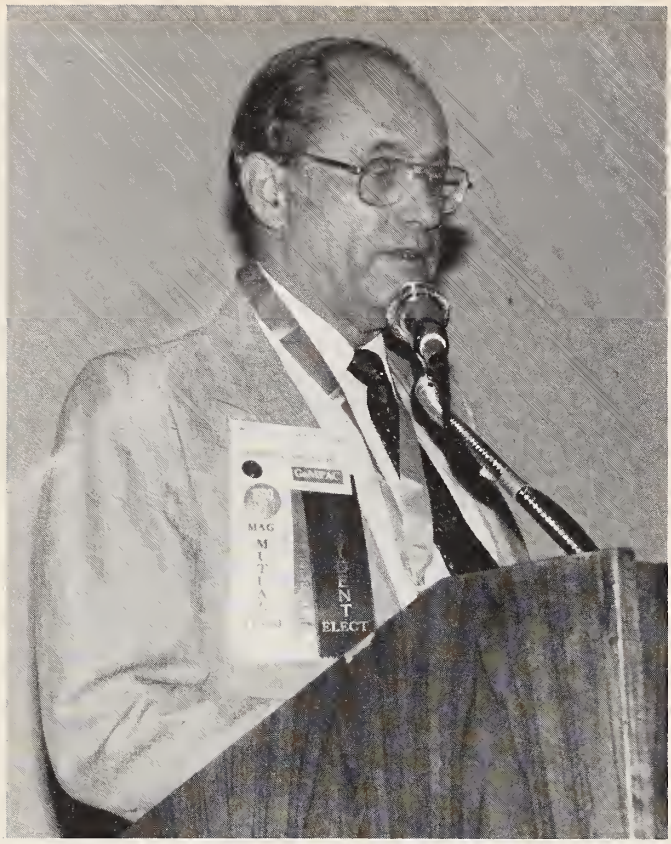


Figure 13 — Newly installed MAG President Charles D. Hollis, Jr., addresses the House briefly at the Final General Session. A priority of Dr. Hollis is *education* — not only of the public regarding good health habits and a more efficient use of the health care system but also of MAG members regarding the many activities the Association is involved in on their behalf.

AMA Delegate — J. Daniel Bateman, Albany
AMA Alternate Delegate — William W. Moore, Jr., Atlanta
AMA Alternate Delegate — Joe C. Stubbs, Valdosta
First District Director — Leon Curry, Metter
First District Alternate Director — Douglas O. Cope, Statesboro
Second District Director — Sammie Dixon, Tifton
Second District Alternate Director — Lanny Copeland, Moultrie
Third District Director — Virgle W. McEver, Warner Robins
Third District Alternate Director — W. A. Spears, Warner Robins
Eighth District Medical Society Alternate Director — S. William Clark, Jr., Waycross
Tenth District Medical Society Director — William M. Headley, Milledgeville
Tenth District Medical Society Alternate Director — William C. Holmes, Athens
Georgia Medical Society Director — Joe Nettles, Savannah
Georgia Medical Society Alternate Director — Clyde L. Olson, Savannah
Medical Association of Atlanta Director — J. Harold Harrison, Atlanta
Medical Association of Atlanta Alternate Director — William C. Waters, III, Atlanta
Crawford W. Long Medical Society Director — William C. Holmes, Athens
Crawford W. Long Medical Society Alternate Director — E. Van Herrin, Athens

President Turk passed the gavel and medallion as symbols of leadership to the incoming president, Charles D. Hollis, Jr., of Albany. Dr. Hollis then presented Dr. Turk with the MAG President's Pin, a bound set of the MAG *Journals* encompassing his presidential year, and a silver gavel inscribed with his name.

Dr. Hollis announced the dates and sites of future MAG House of Delegates meetings as follows: 1983, Columbus, April 21-24, Columbus Hilton; 1984, Jekyll Island, April 5-7, Holiday Inn; 1985, Savannah, April 25-28, DeSoto Hilton.

Dr. Hollis announced the official attendance of the 128th Annual Session as follows: 173 delegates; 26 alternate delegates; 22 members; and 16 guests.

The 128th Annual Session of the Medical Association of Georgia was adjourned at 4:05 p.m.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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of Summary.
nsult the package literature for prescribing information.

lications and Usage: Ceclor® (cefaclor, Lilly) is indicated in treatment of the following infections when caused by susceptible ins of the designated microorganisms:
ower respiratory infections, including pneumonia caused by *ptococcus pneumoniae (Diplococcus pneumoniae), mophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic ptococci)
ppropriate culture and susceptibility studies should be performed etermine susceptibility of the causative organism to Ceclor.

traindication: Ceclor is contraindicated in patients with wn allergy to the cephalosporin group of antibiotics.

rnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALDSPORIN IBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS ICAL AND LABDRATORY EVIDENCE OF PARTIAL CROSS-ERGENICITY OF THE PENICILLINS AND THE CEPHALDSPORINS, THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD CTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES. ntibiotics, including Ceclor, should be administered cautiously y patient who has demonstrated some form of allergy, cularly to drugs.

autions: If an allergic reaction to cefaclor occurs, the drug ld be discontinued, and, if necessary, the patient should be ed with appropriate agents, e.g., pressor amines, antihistamines, rticosteroids.
blonged use of cefaclor may result in the overgrowth of usceptible organisms. Careful observation of the patient is ntial. If superinfection occurs during therapy, appropriate ures should be taken.
sitive direct Coombs tests have been reported during ment with the cephalosporin antibiotics. In hematologic es or in transfusion cross-matching procedures when obulin tests are performed on the minor side or in Coomb g of newborns whose mothers have received cephalosporin otics before parturition, it should be recognized that a ve Coombs test may be due to the drug.
clor should be administered with caution in the presence of dly impaired renal function. Under such a condition, careful l observation and laboratory studies should be made se safe dosage may be lower than that usually recommended.
a result of administration of Ceclor, a false-positive reaction cose in the urine may occur. This has been observed with ict's and Fehling's solutions and also with Clinitest® but not with Tes-Tape® (Glucose Enzymatic Test Strip, Lilly).
ge *in Pregnancy*—Although no teratogenic or antifertility were seen in reproduction studies in mice and rats receiving 2 times the maximum human dose or in ferrets given three he maximum human dose, the safety of this drug for use in pregnancy has not been established. The benefits of the pregnant women should be weighed against a possible the fetus.
e *in Infancy*—Safety of this product for use in infants an one month of age has not been established.

e Reactions: Adverse effects considered related to r therapy are uncommon and are listed below.
rointestinal symptoms occur in about 2.5 percent of and include diarrhea (1 in 70) and nausea and vomiting).
ith other broad-spectrum antibiotics, colitis, including rare es of pseudomembranous colitis, has been reported in tion with therapy with Ceclor.
rsensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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Comments on "Experiments of Nature"

The past 2 decades have produced remarkable advances in medical science. One of the most dramatic has been the progress made in defining and understanding the development, function, and control of the body's immunologic defense mechanisms. Physicians first used this system when Sir William Jenner experimented with immunization for smallpox in 1798. Since that time, immune system related diseases and treatment have played an increasingly important role in almost every area of medicine. Complex new terminology has proliferated, along with the expansion of knowledge about the immune system. One can rarely peruse a medical journal without encountering such terms as immunoglobulin, B cells, T cells, killer cells, suppressor or helper cells, and phagocytes.

Immunology now touches many aspects of medicine unrelated to body defense mechanisms. Immunoassays of various sorts enable investigators to measure vanishingly small quantities of drugs and various body chemicals. Identification and classification of various malignancies, especially those of lymphacytic origin, are now possible. Many researchers are attempting to elucidate the complex control mechanisms of the immune response. Manipulation of such pathways may enable physicians to better treat such problems as collagen vascular diseases and allergic diathecies and, perhaps, enable organ transplants to become more successful.

In this and upcoming issues of the *Journal,* Dr. Margaret Guill reviews the immune deficiency diseases, those "experiments of nature" which have markedly advanced our knowledge of immunity. She has taken a very complicated group of diseases and presented them in a thorough, concise manner. These articles will interest many subspecialists as well as those physicians in primary care areas.

David D. Tanner, M.D.
Allergy/Immunology

Cardioactive Drugs in the Elderly

C. DANIEL CABANISS, M.D., *Columbus**

IT IS NOT SURPRISING that although persons over 65 years of age account for only 10% of the U.S. population, they receive 25% of the prescribed drugs and are more likely to suffer adverse effects.[1] Cardioactive agents are, of course, among the most commonly prescribed agents in the older age group.

Recent reviews underscore the general problem of drug therapy in the elderly and point out that not only is the problem based on poor compliance due to confusion, socioeconomic factors, and lack of supervision but also to altered pharmacokinetics.[2, 3] These altered pharmacokinetics may include age-related changes in absorption, distribution, metabolism, excretion, and receptor sensitivity.[2]

Digitalis preparations, one of the most commonly prescribed cardiovascular drugs, should be used only for clear-cut indications, and each patient should be carefully reviewed for appropriateness of such therapy.[4]

In the age of purified cardiac glycosides, the prominent extra cardiac symptoms (nausea, vomiting, diarrhea, altered color vision) are unusual. An exception in the elderly patient is the occurrence of insidious and marked appetite loss that may on occasion produce significant weight loss. In the elderly patient, digitalis intoxication presents most commonly as cardiac dysrhythmia of diverse types.

Careful consideration of altered pharmacokinetics of drugs in the elderly is essential.

Anti-depressants in elderly patients may cause perplexing EKG changes predominantly involving repolarization, such as STT changes and QT interval prolongation. As in QT prolongation syndromes of other etiologies, serious ventricular arrhythmias may result.[5]

Bronchodilators are virtually always cardioactive and may contribute to troubling or life-threatening ventricular and atrial arrhythmias. Appropriateness of therapy should always be considered, and where applicable, blood levels should be monitored.

Anti-arrhythmic agents are frequently a source of problems in the elderly. The quinidine-digoxin interaction is now widely recognized after eluding clinicians for many years.[6] It is particularly a problem in the older patient because of age-related

* Dr. Cabaniss practices internal medicine. Send reprint requests to him at P.O. Box 951, Columbus, GA 31902.

Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

pharmacokinetic changes. As a general rule, digoxin dosages should be reduced by half in the elderly patient who is to receive quinidine. Blood levels of both drugs should be measured after 1 week of concomitant therapy.

In all patients, and especially in the elderly receiving quinidine, the EKG should be monitored, and if QT prolongation occurs in the presence of continued ventricular ectopy, the clinician should be forewarned of the possible occurrence of malignant dysrhythmia.

Disopyramide (Norpace) must be used with caution, if at all, in older patients. Potent and serious effects on ventricular function may produce sudden and unexpected ventricular failure, especially if subclinical impairment of ventricular dynamics preexists.[7] Additionally, in older men, lower urinary tract obstruction and exacerbation of glaucoma in both sexes may ensue with disopyramide due to the drug's marked anticholinergic effect.

Increased sensitivity to beta blockers may manifest in old age. Latent sick sinus syndrome may be unmasked as sinus node function is depressed. Extreme fatigue and emotional depression seem more prevalent clinically with beta blockers in the elderly as does exacerbation of peripheral arterial insufficiency.

A particular word of warning is needed on timolol eyedrops, a beta blocker used in the therapy of glaucoma. In elderly patients with compromised cardiac function, systemic absorption of this agent may render congestive heart failure more difficult to control.

Caution is certainly indicated in the use of calcium channel antagonists in elderly patients until the pharmacokinetics of these drugs are more clearly understood in the elderly population. It has already been demonstrated that verapamil will significantly elevate serum digoxin levels when these drugs are co-administered.

Lastly, a significant clinical interaction between methyldopa and digoxin may produce significant and symptomatic sinus bradycardia especially in elderly patients.[8] This poorly understood interaction may on occasion lead to consideration of pacemaker therapy if not recognized.

The foregoing is by no means a complete catalog of the many problems of cardiovascular drug therapy in older patients but does represent some important and not uncommon problems in my experience.

General principles to follow are: (1) carefully consider appropriateness of a given drug in an older patient; (2) consider reduced dosages; (3) consider pharmacokinetics of a particular drug in the elderly; (4) review existing drug therapy for possible interactions; (5) seek means of increasing compliance in the elderly by such means as reducing frequency of dosage and written ''drug calendars''; (6) employ measured blood levels more liberally in this group of patients; (7) when unusual symptoms or signs occur, carefully review current drug therapy as a possible etiology.

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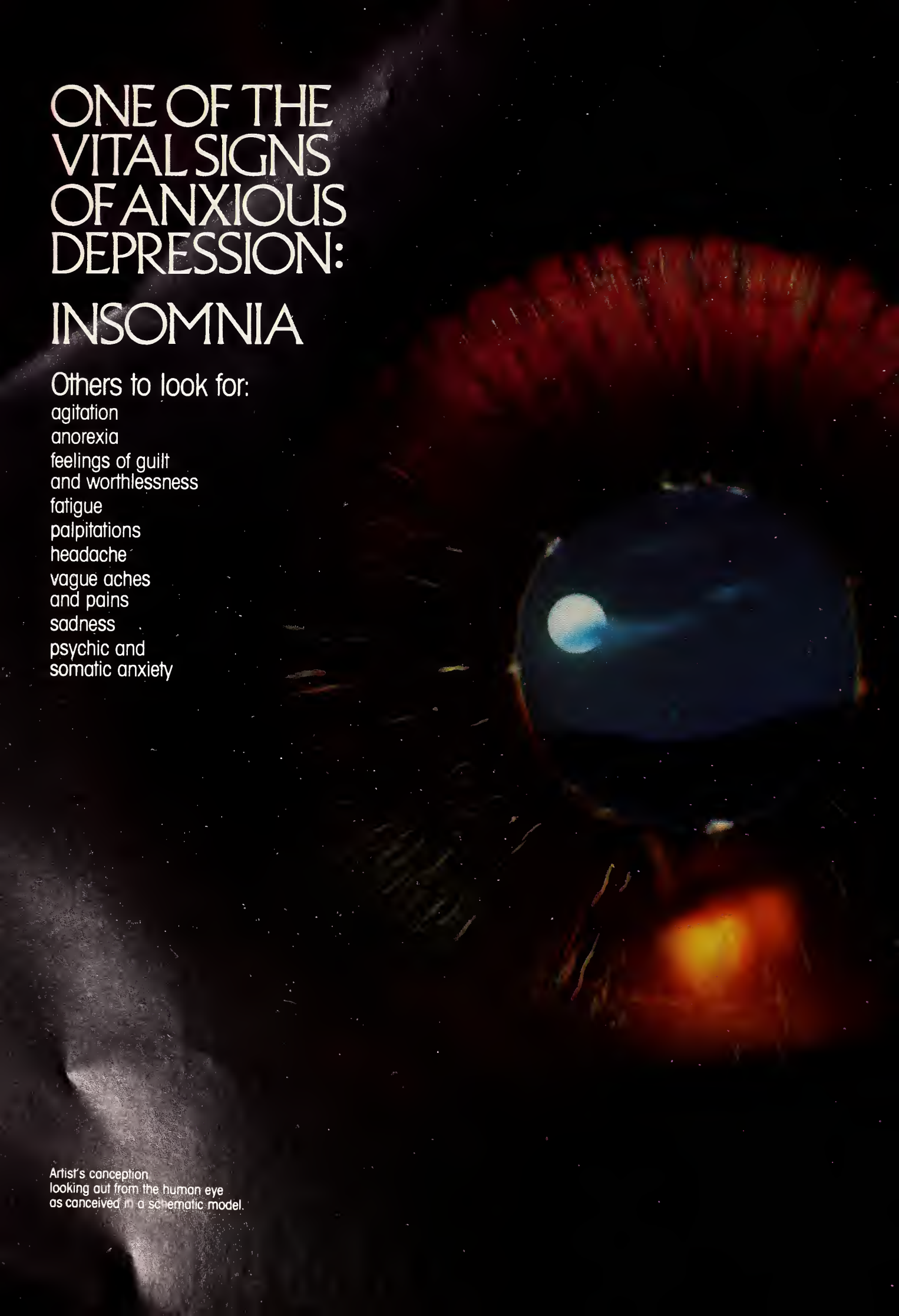
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anorexia
feelings of guilt and worthlessness
fatigue
palpitations
headache
vague aches and pains
sadness
psychic and somatic anxiety



Artist's conception looking out from the human eye as conceived in a schematic model.

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Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriosis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

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Physicians as Witnesses — Rights, Obligations, and Reasonable Compromise

F. C. SCHENCK, *Atlanta**

ATTORNEYS INVOLVED in personal injury litigation regularly find it necessary to obtain the testimony of physicians. Most often, the medical testimony is taken by deposition and is used to assist the attorney in evaluating the injured party's claim for purposes of arriving at a fair and reasonable settlement. Of course, in those cases where the issue of liability or the extent of injury cannot be resolved by discovery and negotiation, it may be necessary to present the medical testimony to a jury at the trial of the case.

In such instances, the medical testimony may be presented either by deposition or by having the physician appear and testify in person. While either of these alternatives is acceptable, a jury may be more attentive to live testimony than to the reading of a deposition. It is for this reason, especially where the medical testimony is crucial to the outcome of the case, that attorneys often ask physicians to appear in court even when their deposition has already been taken.

When a physician is required to serve as an expert witness, either at a deposition or a trial, a clash of opposing wills and interests may occur. On the one hand, the physician may view a request to serve as an expert witness as an unwanted and unnecessary intrusion into his or her practice; in the physician's view, he or she spent countless hours of study and preparation and made a significant personal sacrifice to become a physician, not a professional witness. On the other hand, the attorney, in order to fully represent his/her client, must obtain all information and evidence relevant to his/her client's case.

How does the law reconcile this conflict? As will be discussed below, the law is decidedly in favor of the attorney. The physician can be compelled to testify — and at a reimbursement rate far below that which the physician earns in the practice of medicine. At the same time, however, there are obvious practical reasons why the attorney will not want to exercise to the fullest extent that which the law allows. The physician who is forced to testify against his or her will may testify in such a way that the attorney's case may not be benefitted. For these reasons, it behooves both the attorney and the physician to be cooperative and reasonable in situations where the physician's expert testimony is needed.

This is not always the case, however. For example, the physician, in an effort to dissuade the attorney from taking his or her deposition or requiring his or her testimony in court can demand an exorbitant fee for testifying. He or she can otherwise make unreasonable demands upon the attorney, such as by continuously rejecting proposed dates, places, or times in scheduling depositions. Conversely, the attorney can also make unreasonable demands upon the physician, such as offering to pay an absurdly low fee for the physician's testimony on behalf of his

* Prepared at the request of the Medical Association of Georgia. Mr. Schenck is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

client, by scheduling depositions on short notice, or by failing to take the physician's schedule into consideration.

Accordingly, it is appropriate to summarize the legal rules governing the obtaining and use of expert medical testimony and to reinforce the fact that attorneys and physicians must engage in compromise, not combat, if the full interests of the patient are to be served and the goals of our judicial system are to be achieved.

The Legal Obligation to Serve as a Witness

Generally, a licensed physician need not release medical information concerning a patient except in response to an appropriate court order, subpoena, or upon written authorization of the patient.[1] Moreover, by releasing such information only in response to one of the above, the physician is protected from liability.[2] At the same time, it should be understood that patients waive the privilege that attaches to such medical information any time they place their care and treatment or the extent of their injuries at issue in any civil or criminal proceeding.[3] In those situations, the attorney representing the party opposing the patient has the right to obtain patient information in the possession of the physician relevant to the case.

Although there are numerous ways the attorney may obtain this information, the usual procedure is for the attorney to serve the physician with a subpoena. Upon receipt of the subpoena, the physician has two choices: comply with the subpoena or file a motion to quash with the court, such as where the subpoena is overly broad, burdensome, or seeks information other than that relevant to the case. Assuming that the subpoena is properly prepared and served, however, the law states that all persons have a duty, absent a statutory exemption, to attend and testify in accordance with the terms of the subpoena.[4] No such statutory exemption exists for physicians.

A party to a civil suit may secure a subpoena from the appropriate court as a matter of right.[5] The subpoena must be issued by the Clerk under the seal of the court, it must state the name of the court and the title of the action, and it must command the person to whom it is directed to attend and give testimony at a time and place therein specified.[6]

A patient waives the privilege that attaches to personal medical information any time he places his care and treatment or the extent of his injuries at issue in any civil or criminal proceeding.

Although the subpoena may be served by a sheriff, a deputy, or by any other person not less than 18 years of age, state law also permits service by registered or certified mail. The subpoena may also command the person to whom it is directed to produce whatever tangible evidence he has in his possession relating to the matter of the subpoena.[7]

The only statutory reimbursement to which a witness is entitled is a $10 witness fee, together with reimbursement for mileage at the rate of $0.20 per mile. In cases in which the witness resides in the county where his or her testimony is to be given, the witness may be required to appear at the deposition or trial and present his or her claim for reimbursement to the Clerk of the Court. In cases where the witness resides outside the county where he or she is to testify, the subpoena, to be valid, must be accompanied by tender of the $10 witness fee plus mileage of $0.20 per mile for traveling expenses.[8] It should also be noted that a subpoena requiring the attendance of a witness at a hearing or trial may now be served at any place within the State of Georgia.[9]

The penalties involved in failing to comply with a subpoena are significant. Under Georgia law, subpoenas may be enforced by attachment for contempt, by a fine not exceeding $300, and/or by imprisonment not exceeding 20 days.[10] If the subpoena is in proper form and properly served, the court will only consider whether, under the circumstances of the case, the subpoena was served within a

reasonable time prior to the time specified therein for appearance, but not less than 24 hours prior to that time.

The above rules apply whether the subpoena is being used to compel attendance at a deposition or at trial. Moreover, witnesses, properly subpoenaed, are under an obligation to further the administration of justice by appearing and testifying as to any relevant facts within their knowledge.[11] The reason for this, according to the courts, is that "[t]he ultimate end of all litigation is the ascertainment and rendition of the truth. The truth can be determined only through the sworn testimony of witnesses. Thus, any person not privileged having knowledge of issues being tried should be made available to the parties as witnesses."[12] Of course, as noted above, sometimes that testimony is given at a deposition and sometimes the witness is called to testify. Regardless of the method the attorney selects, the witness is compelled to testify. Moreover, "[o]nly when expressly provided by law can the privilege of a witness resist the demand of justice for the truth, and the witness refuse to answer a legal question."[13]

It is clear that a physician, just as any other citizen, may be required to appear and testify either at a deposition or trial with respect to those facts known to him which are relevant to the issue of the condition of a patient when, for whatever reason, that condition has become an issue in a legal proceeding. Moreover, there is nothing in the law that requires that a physician be compensated for his time when he so testifies beyond the witness fee and mileage required by statute. This is true even when the physician is testifying as an expert. In fact, the Georgia Court of Appeals has said that "[a] physician is competent to testify as an expert, and no expert can refuse to testify because he has not been compensated or will not be compensated for his testimony. An expert testifying as a witness has no greater privilege than any other witness."[14]

The Need For a Practical Compromise

Even though the law has given the attorney the tools necessary to compel a physician to testify, there are obvious practical reasons why the attorney would be performing a disservice to his client by choosing to exercise the full extent of his legal rights. For example, the attorney who "strong arms" the physician into testifying may find that the physician is less than totally cooperative. This occurred in one Georgia case, and the Georgia Court of Appeals held that the physician's hostility could be viewed by the jury in determining the physician's credibility.[15] This is a result which the attorney should seek to avoid.

Perhaps more important from a practical standpoint is the fact that even though a physician may be compelled to testify, he or she is under no duty to prepare for that testimony by reviewing pertinent files, conducting other research, etc. In the absence of such preparation, the testimony may prove to be vague, unconvincing, or poorly documented.

Moreover, it is incumbent upon the attorney, perhaps as much out of professional courtesy as for any other reason, to recognize that the physician is reasonably entitled to some compensation for the time he or she is asked to be away from his or her practice to testify concerning one of the physician's patients. For these and other reasons, the attorney is well advised to enter into discussions with the physician concerning the latter's testimony with an attitude of reasonableness and with the expectancy of working out a compromise, rather than with an overly aggressive, combative attitude, and with the intention of obtaining the physician's testimony without considering the circumstances involved or the need to extend certain courtesies to the physician.

One of the ways to minimize the inconvenience to a physician is to take the deposition in advance of the trial at a time and place that are mutually convenient to the attorney and the physician. While this may go a long way toward accommodating the physician, it does not always mean that the physician may not still be called to testify at the trial. First of all, as mentioned above, it may be much more effective to have the physician testify in person. Secondly, with respect to the use of

depositions at trial, Georgia law provides that "[t]he deposition of a witness, whether or not a party, may be used by any other party for any other purpose if the court finds: . . . that because of the nature of the business or occupation of the witness it is not possible to secure his personal attendance without manifest inconvenience to the public or third persons. . . ."[16] This is the statute that many physicians refer to when they suggest that the law permits the reading of their depositions at the trial.

In fact, whether or not a deposition may be used in court lies exclusively within the discretion of the trial judge.[17] Thus, even in those cases in which an attorney wants to tender a physician's deposition into evidence, the court, upon objection to the use of a deposition of a witness who is not present, must make a finding that one of the conditions in the statute exists before the deposition may be used.[18]

In actual practice, however, it is generally agreed between the attorneys that, as a matter of professional courtesy, the deposition will be used at trial, and no objection is made. Furthermore, as a practical matter, it is not difficult to establish the required unavailability and, in fact, the Georgia Supreme Court has held that an attorney seeking to introduce such a deposition may himself take the stand and testify as to the unavailability of the individual whose deposition is sought to be admitted. Such testimony may constitute a sufficient showing of unavailability.[19] This is one reason why many attorneys will question the physician about his workload and availability for trial at the time of the deposition, in order to lay a foundation for the introduction of the physician's testimony by way of deposition at the trial of the case.

The specifics involved in obtaining the deposition or trial testimony of the physician should be worked out to the satisfaction of *both* individuals. For example, the physician should receive notice of the deposition or trial date well in advance of that date whenever possible. In fact, the attorney should permit the physician to participate in setting a date, time, and place for taking his or her deposition. Moreover, the question of compensation should be handled through compromise and reasonableness, rather than through "hardball" negotiations. The attorney, on behalf and obviously with the consent of his client, should offer to pay a fee that is reasonably designed to compensate the physician for the time in which the physician is taken away from his or her practice. Alternatively, the physician should not demand a fee for testifying which is designed to discourage the attorney from obtaining his or her testimony, rather than to compensate the physician for time actually spent in testifying.

In summary, physicians should recognize the obligation that they, as all other citizens, owe to the judicial system, that physicians are not entitled by statute to compensation for their testimony beyond the compensation due any other witness, and that they will maximize the benefit and minimize the inconvenience to themselves and their patients if they take a reasonable and cooperative attitude toward attorneys who are merely trying to perform a service for a client.

At the same time, the attorney must recognize that the physician will make a far better witness if he or she is testifying as a result of a fair and reasonable agreement between the physician and the attorney, rather than as a result of the attorney's uncompromising demand. Accordingly, while the physician may be obligated to serve as a witness and, in doing so, to receive only the minimal witness reimbursement, the attorney will be far better off in the long run if he or she avoids these legalities and proceeds in the spirit of cooperation and compromise.

Notes

1. Ga. Code Ann. §38-418(b). 2. *Ibid.* 3. *Ibid.*
4. *Logan v. Chatham County,* 113 Ga. App. 491 (1966). 5. Ga. Code Ann. §38-801(e).
6. Ga. Code Ann. §38-801(a). 7. Ga. Code Ann. §38-801(b), (c). 8. Ga. Code Ann. §38-801(d). 9. Ga. Code Ann. §38-801(e).
10. Ga. Code Ann. §38-801(f). 11. *Wynne v. State,* 139 Ga. App. 355, 357 (1976). 12. Note 4, *supra,* at p. 492. 13. *Ibid.*
14. *Dixon v. State,* 12 Ga. App. 17 (1966); *see also* note 4, *supra,* at p. 492.
15. *Clayton County Board of Education v. Hooper,* 128 Ga. App. 817 (1973).
16. Ga. Code Ann. §81A-132(a)(3) (in pertinent part). 17. Ga. Code Ann. §81A-132(a)(4).
18. *Building Assoc. v. Crider,* 141 Ga. App. 825. 19. *Sheffield v. Lockhart,* 151 Ga. App. 553 (1979).

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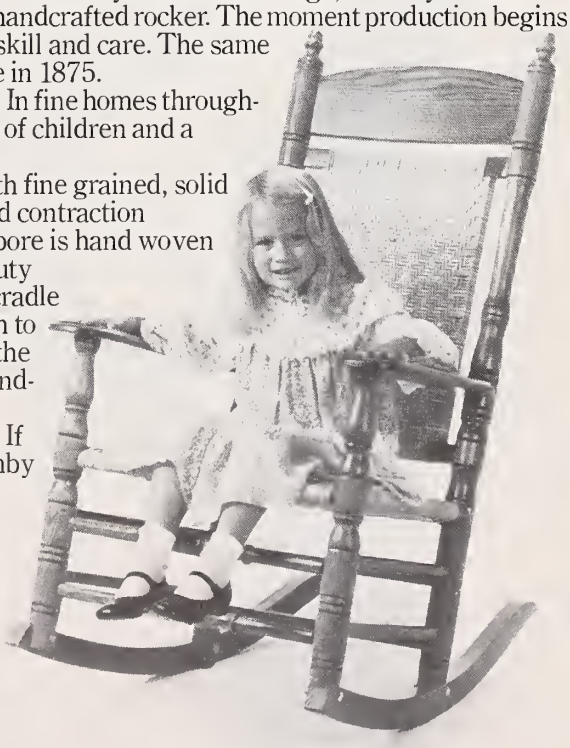
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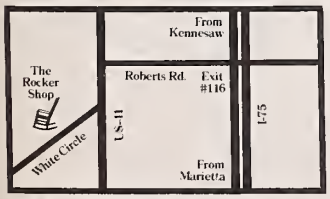
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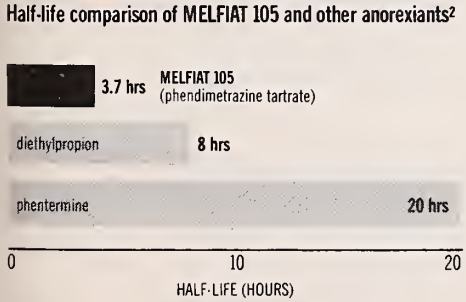


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References: **1.** Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine,* unclassified document ADAMHA, HHS. Office of Medical and Professional Affairs, NIDA, 1980.
2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

MELFIAT® 105 UNICELLES® C III
(phendimetrazine tartrate) Sustained-Release Capsules 105 mg

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MELFIAT® 105 UNICELLES® C III
(phendimetrazine tartrate) 105 mg Sustained-Release Capsules

INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.
Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
Allergic: Urticaria.
Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear sustained-release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.

Reid-Provident Laboratories, Inc.
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president's letter



We Are Never Off Duty

It is an overwhelming thought. It is sometimes difficult to face. Awesome responsibilities are involved. We can make business and practice arrangements for a periodic respite. But the fact remains: we are never off duty.

The obvious and primary obligation of the physician is to his patients — 24 hours a day. The hour-by-hour attention to the patient can be shared with our colleagues. Much that is required of us in fulfilling our role in society, however, cannot be shared. Of all groups in our society, the most comprehensive educational opportunities have been made available to physicians — in both the humanities and the sciences. People in general recognize this and respect us for it. But to whom much has been made available, much is also expected. Polls indicate that we are not measuring up to public expectations in many ways and that our image is suffering.

We often feel that our work is demanding and that our hours are long. How much more can we do? Actually, a great deal more, because we are never off duty!

The demeanor and personal conduct of the physician must be exemplary. He must inspire faith. He must be in control of himself — professionally, socially, and personally. A patient should be able to say with pride and confidence, "That's my doctor." Necessarily, then, we are never off duty.

The physician must participate in community affairs. His role makes his involvement in church, civic, and charitable organizations very important. He must be a good citizen as well as a good doctor.

As physicians, we have spent much of our available time in educational pursuits. Thus, inevitably, we have become physician educators — as members of governing boards and schools, as public instructors demonstrating the indispensable place of education in personal development and good mental and physical health, and as tutors for our colleagues in advancing the concept of the *quality* of life and not just the *length* of life.

No one in American society has more of a vested interest in the maintenance of sound government and a stable economy than we who practice medicine. The good things that we have learned to accept in this country did not happen by chance. A privileged, dedicated few worked after hours to make it a reality. We in medicine are now among the privileged few. As physicians, it is up to us to help continue the legacy of the free society that we have inherited — after hours when necessary.

This is a big order, an imposing task for any person. Is it possible to live up to such a role?

It is not only possible but also vital for the continued well being of our profession and our society. It is possible, but not if we attempt to go it alone. The world is too big and the challenge is too great for the lone individual. It is possible, but only if we accept our responsibility and work as a team — as an organized medical team. Only the team can face effectively and solve the problems we encounter as physicians and as members of a free society. As a team, then, we must choose our priorities carefully. To fulfill our role, we must remember that we are never off duty.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.
President, MAG

NEW MEMBERS

Brumley, George W., MAA—ACT—PD
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35 Linden Avenue, NE, Atlanta 30315

Hopkins, Linton C., MAA—ACT—N
1365 Clifton Road, NE, Atlanta 30322

Isley, Robert A., Gwinnett-Forsyth—ACT—PD
2121 Fountain Drive, Ste. A, Snellville 30278

Jayaraj, H. C., Peachbelt—ACT (N-2)—IM
212 Hospital Drive, Warner Robins 31093

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1938 Peachtree Road, Suite 101, Atlanta 30309

Mattas, Anne K. T., Richmond—ACT (N-2)—IM
Dept. of Internal Medicine, MCG, Augusta 30912

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777 Hemlock St., Macon 31201

Wade, Jim R., Stephens-Rabun—ACT (N-2)—IM
800 E. Doyle St., Toccoa 30577

Wood, James R., MAA—ACT (N-2)—NS
1365 Clifton Rd., NE, Div. of Neurosurgery, Atlanta 30322

PERSONALS

Third District

Raymond C. Ho, M.D., of Americus, was elected to Fellowship in the American Academy of Pediatrics. Dr. Ho is on the staff of and the former Chief of Pediatrics at the Americus and Sumter County Hospital and serves as adjunct professor at Georgia Southwestern College. He has also been named to the Marquis, the Who's Who directory listing of medical specialists in the United States.

Fifth District

William A. Hopkins, M.D., of Dunwoody, has recently been named a member of the Board of Directors for the new St. Joseph's Hospital Foundation. Dr. Hopkins performed the first open heart surgery in Georgia in 1957. He is a member of the American Board of Surgery and the Board of Thoracic Surgery.

Peter J. Sones, Jr., M.D., associate professor of radiology at Emory University School of Medicine, recently spoke to a group of physicians and registered nurses at the Americus and Sumter County Hospital.

W. Dean Warren, M.D., was elected president of the American Surgical Association. He has been chairman of surgery at Emory since 1971. Dr. Warren is internationally known for his development of a liver-shunt operation to control the bleeding of alcoholic cirrhosis and other liver problems.

Bernard S. Lipman, M.D., an Atlanta physician, was the recipient of Israel's Maimonides Award at a dinner held in Atlanta on April 29. The award is given for notable leadership and outstanding participation in the Health Professions and Service Division of Israel Bonds and for devoted support to develop the economy of the State of Israel as a means of realizing its hopes for a future of peace and progress.

Eighth District

Charles O. Barker, M.D., of Valdosta, spent 3 weeks in Africa in February treating adults and children. Part of the mission effort was to help the Africans by providing them with basic nutritional information.

C. J. Roper, M.D., of Jasper, at the age of 76, has recently retired because of poor health. In the mid-1950s, Dr. Roper served for 2 years in the State Senate to help pass some health care bills.

Tenth District

Augusta pediatrician, **Robert C. McGahee, M.D.,** has been named a Paul Harris Fellow by the Augusta Rotary Club. He is an emeritus clinical professor of pediatrics at the Medical College of Georgia and has been president and secretary of the Richmond County Medical Society, President of the Georgia Pediatrics Society, honorary president of the Georgia Chapter of the American Academy of Pediatrics, and vice president of the Medical Association of Georgia. The Paul Harris Fellowship is given for community service.

Bashir A. Chaudhary, M.D., assistant professor of medicine at the Medical College of Georgia, has been elected secretary of the Southern Chapter of the American College of Chest Physicians, and also elected secretary of the Southern Medical Association, Section of Chest Diseases.

Harry T. Harper, Jr., M.D., was honored recently by the Medical College of Georgia for his years of service in medicine. Dr. Harper is in private practice in Augusta. He served on the MCG faculty from 1937 until 1952.

Augusta physician, **Carol Graham Pryor, M.D.,** is the 1982 recipient of the Georgia College Alumni Achievement Award. Dr. Pryor was the first woman in Georgia to be certified by the American Board of Obstetrics and Gynecology and was the first woman to become a member of the Georgia Chapter of the American College of Surgeons. She was Medical Woman of the Year in 1961.

A. Calhoun Witham, M.D., professor of medicine at the Medical College of Georgia, was recently elected vice president of the Association of University Cardiologists at the organization's annual meeting.

Athens' otolaryngologist, **A. Paul Keller, M.D.,** is serving on the Board of Directors of the new American Academy of Otolaryngology.

DEATHS

John D. Deal

John D. Deal, M.D., 64, died April 11 in Augusta. Dr. Deal was a native of Bulloch County. He received his medical degree from the Medical College of Georgia. Dr. Deal had practiced medicine in Statesboro for the past 31 years. At the time of his death, he was on the Medical Staff at Bulloch Memorial Hospital in Statesboro.

Dr. Deal is survived by his wife, one daughter, one son, two sisters, and one brother.

John Arthur Wilhelm

John Arthur Wilhelm, M.D., of Kennesaw died April 23, at the age of 66. Dr. Wilhelm was a physician in Florida and served as medical director and vice president of Gulf Life Insurance Co. He later was director of surgical services at the University of Miami, Fla. He also had a private practice in Marietta.

Survivors include his wife, three sons, 11 grandchildren, and two brothers.

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Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from January through March, 1982.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

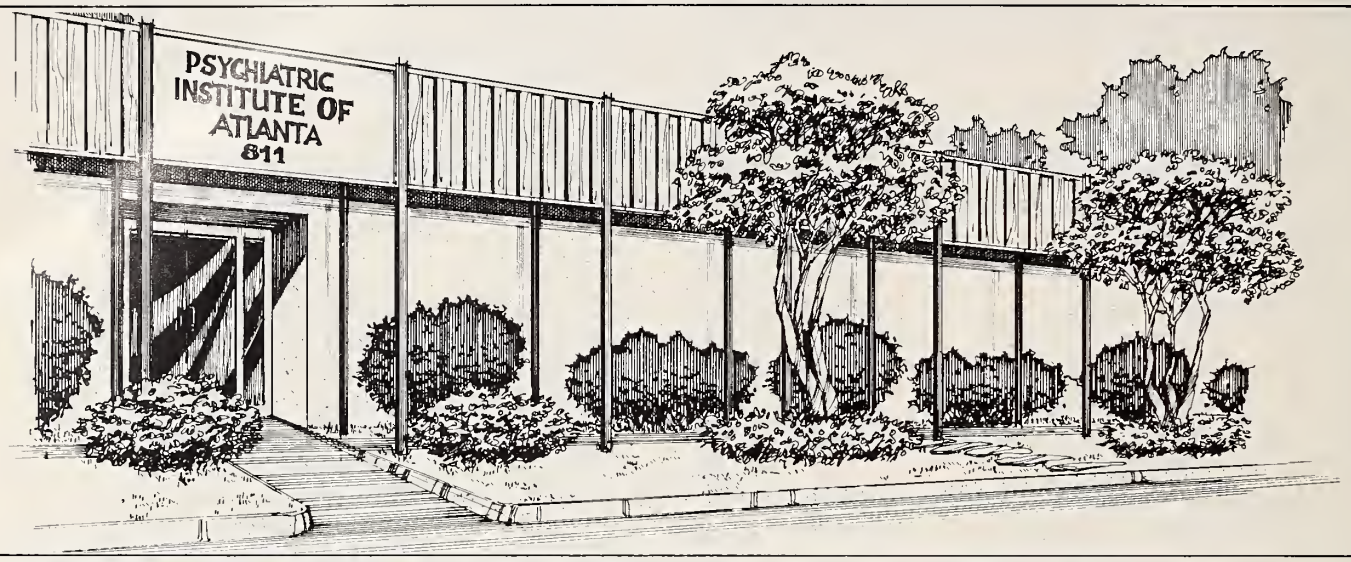
The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Emile G. Abbott, Conyers
Robert Jay Alpern, Smyrna
William J. Anderson, Decatur
Pacificio Aranas, Thomasville*
Arcot D. Ashok Kumar, Columbus*
Earnest C. Atkins, Atlanta
Ramon P. Azahar, Milledgeville*
John Hagan Baskin, Atlanta
Irwin Ralph Berman, Brunswick
Marcus Lynn Black, Statesboro
Paul W. Black, Atlanta
Augustus F. Bloodworth, Gainesville
Donald L. Boyd, Albany
William A. Boyson, Fort Gordon*
Paul L. Bradley, Dalton
Melvin Lynn Butler, Fort Gordon*
Bernard J. Cahn, Atlanta*
Jose C. Campa, Valdosta
Miriam W. Chambless, Hamilton
Robert W. Crow, Atlanta
Eugene D. Davidson, Atlanta
Thomas A. Davis, Valdosta
Howard C. Derrick, LaFayette
Richard M. Draffin, Savannah*
Lawrence J. Duane, Waycross
Dan Berlin Elrod, Hazlehurst
Hossam E. Fadel, Augusta
Michael B. Feinerman, Atlanta
Juan A. Fernandez, Douglasville*
Michael E. Fincher, Hinesville*
Elliott R. Finger, Savannah
Robert E. Fokes, Moultrie
Paul David Forney, Martinez*
Norman Isaac Goldman, Columbus
Howard A. Griffin, Waycross
John Michael Griffin, Atlanta
Kenneth Lee Haile, Marietta
John Harold Hartley, Atlanta
Carl R. Hartrampf, Atlanta
Charles D. Hollis, Jr., Albany
William Elliott Huger, Atlanta
Stephen C. Hunter, Columbus
Otto B. Johnson, Dublin
Alexander Kelter, Atlanta*
Michael B. Kessler, Atlanta
Charles R. King, Moultrie
Jonathan S. Krauss, Augusta
Dianne Cheryl Leeb, Tucker
John Ransom Lewis, Jr., Atlanta
Werner A. Linz, LaGrange
Mark Alan Lloyd, Atlanta*
William Ernest Logan, Martinez*
Charles G. Magnan, Macon
Herschel U. Martin, Dalton
Stanislaw Martynski, Fort Oglethorpe
Richard C. Mattison, Atlanta
William Edgar Mayher, Albany
William Theron McLarty, Smyrna
Elfriede M. Mellinger, Augusta*
Jose Enrique Mendizabal, Canton
Byron Donald Minor, Decatur
Chester William Morse, Decatur
John Charles Munna, Atlanta
A. Wendell Musser, Decatur*
Thomas Robert Nolan, East Point
Izhak Oliver, Lithia Springs
Cylde Lewis Olson, Savannah
Mary Louise Osborne, Fort Benning
John Burrell Otis, Atlanta
Robert Milford Packer, Waycross
Garland D. Perdue, Atlanta
Thomas Wilson Phillips, Atlanta
James W. Purcell, Covington
Roberto Alfonso Rey, Milledgeville*
Emilio B. Ruelos, Griffin*
Kenneth Antony Scheidt, Atlanta
D. Gamini Seneviratne, Columbus
George Paul Shaw, LaFayette*
Edwin C. Shepherd, Savannah
Eloise B. Sherman, Savannah
D. Siddappa, Atlanta*
Ada Kathleen Skinner, Austell*
William G. Slaughter, Thomasville*
Morton Slutsky, Atlanta
William Arthur Smith, Atlanta*
David S. Sowell, Hapeville
Charles R. Stafford, Augusta*
Henry E. Steadman, Atlanta
Byron Harold Steele, Fairmont
Robert F. Sullivan, Carnesville
Karen Deborah Sumers, Atlanta
George D. Talbott, Smyrna
James Mason Tallman, Marietta
Lavon Thurman, Columbus
Robert J. Van de Wetering, Atlanta
John Henry Vassall, Decatur
Joe Martin Webber, Columbus*
Richard A. Wherry, Dahlonega
Paul Austin Whitlock, Statesboro
William A. Williams, Macon
Fremont Philip Wirth, Savannah
John Gordon Zirkle, Savannah
George Lionel Zumbro, Augusta

* Non MAG member.

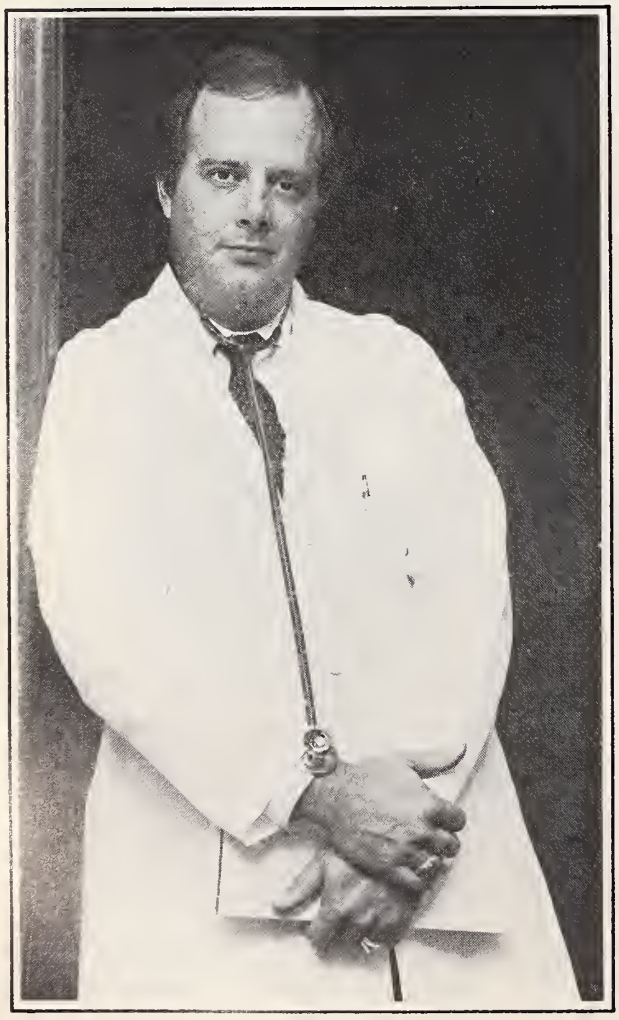
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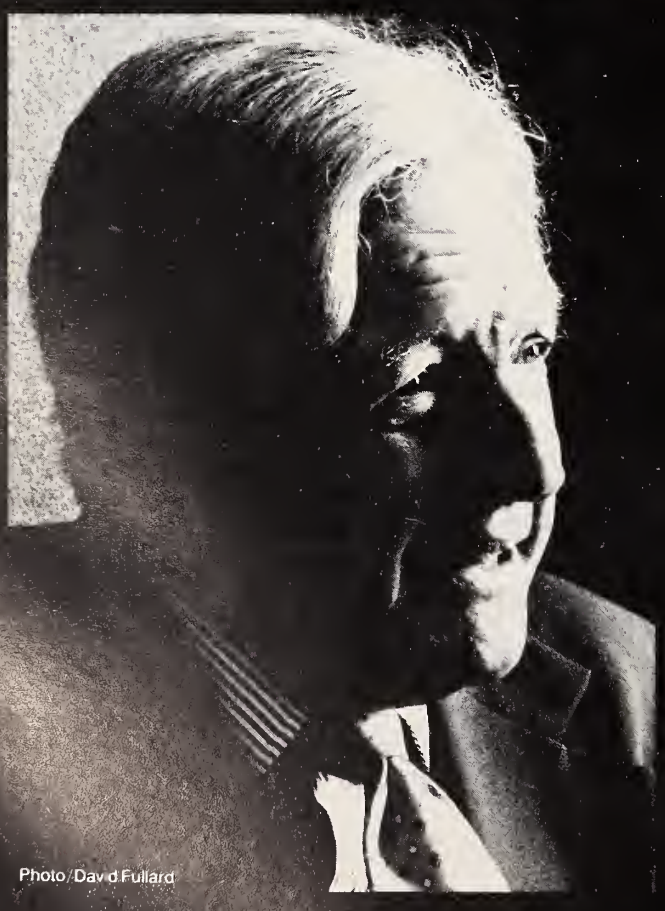
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"When I saw a cripple, I'd stop stark still and walk across the street."



Photo/David Fullard

In explaining that reaction, Dr. Colter Rule, a practicing psychiatrist says, "I guess it was a mirror and I was unacceptable to myself."

Dr. Rule was disabled by polio as a child. At five he was sent to an institution that was hundreds of miles from his home. That year away—which he remembers as more like ten years—resulted in a permanent emotional severance from his family. "The way my family responded made me feel it would have been better if I hadn't been born. At the institution, I perfected a superficial charm to get attention and approval. But inside there was an enormous rage that stayed with me for years. As an example of my negativism, when members of my family stressed that it was lucky I could play the piano, since I couldn't dance, that was the last time I touched the piano.

"When I became a doctor I thought, now, I will be dealing with the sick and I won't have to deal with myself. That's why it took me such a long time to identify or get involved with the problems of the disabled."

Dr. Colter Rule sums it up in these words today, "We must work and learn together. After all, an abused child can be more seriously disabled than someone who has difficulty with coordination. We must stop treating any disabled person as a loser and begin to build gateways for them through which they can join the rest of the world."

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JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, GA 30309-3990

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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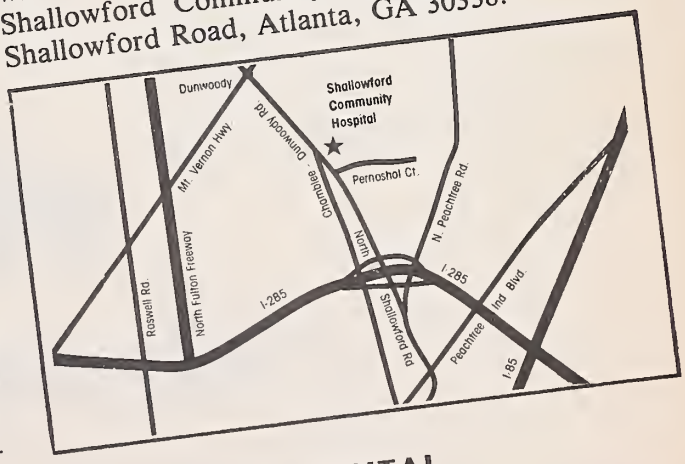
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Shallowford Community Hospital, a young, progressive facility with eight years of service, has 178 licensed beds. The hospital offers a full range of patient services, including 24-hour ER, modern surgical facilities, ICU/CCU, outpatient, cardiology, radiology, pharmacy, clinical laboratory, respiratory therapy, physical therapy and social services. In addition to these services, Shallowford recently opened a new addition which contains:

- A new, comprehensive obstetrics unit with Level II perinatal services and stabilization nursery;
- A vastly expanded CCU, with state-of-the-art monitoring equipment; and
- Increased diagnostic capabilities in cardiology, vascular and pulmonary services.

For a complete description of Shallowford Community Hospital's medical staff needs and physician assistance programs, a confidential contact to the Executive Director of Physician Relations is suggested. In Georgia, call toll-free 800-342-9660 (outside Georgia: 800-841-9403), or write: William F. Lee, Administration, Shallowford Community Hospital, 4575 North Shallowford Road, Atlanta, GA 30338.



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THE COVER

The quality of medical care offered by the HMO delivery system continues to be a debated issue. Predictably, opinions vary. Dr. Felder expresses his in the editorial on page 508.

Cover design by Jill Harris Brown, of Atlanta.

Incidental Intelligence . . .

MAG Mutual Is Now Operational





On June 1, 1982, MAG Mutual Insurance Company received its Certificate of Authority to begin issuing insurance policies. In the photograph at left, MAG Mutual President Charles D. Hollis, Jr., M.D. (left), and Howard Lamb, MAG Mutual Executive Vice President, look on as Insurance Commissioner Johnnie Caldwell signs the Certificate. Right photo, Dr. Hollis and Commissioner Caldwell review the Certificate. Joining them (from left to right) are Bert Franco, Executive Vice President, Marketing, MAG Mutual; Robert P. Constantine, MAG Mutual attorney; Howard Lamb, Executive Vice President, MAG Mutual; and Hugh Edenfield, Assistant Deputy Insurance Commissioner. All physicians will be contacted by the company regarding their professional liability insurance. Members are urged to contact MAG Mutual if they have any questions about their coverage with the company.

Committee Report Department . . .

(As part of our continuing effort to inform our membership of the activities of the Association, we are initiating this new "Department" in the Journal. *In it we will publish the reports of various committees that recently reported to the Executive Committee.)*

Physician-Lawyer Liaison Report — Controversy Brews Over Principles Governing Inter-professional Relations

The Medical Association of Georgia and the State Bar of Georgia established a joint Physician-Lawyer Liaison Committee which agreed on a set of Principles governing inter-professional relations in 1969. The aim was to establish understanding and cooperation between the professions. The State Bar has now passed a new set of Principles containing a fee schedule which may be illegal for us to adopt. The new Principles were approved by the Bar without our advice or consent, but there is reason to believe that the Bar Association in general was under the impression that the medical community had approved them.

Although we should not approve the Principles with a fee schedule as adopted by the Bar Association, the fact that the Bar's Principles do contain a fee schedule is expressive of an element of discontent concerning the fees many physicians are charging for legally related services. While most of the complaints referred to this committee involve disputes over payments for depositions or possible unethical practices by members of both professions, most of the antagonism is being generated over very small sums of money. Lawyers most frequently complain, though not formally, that the response to a request for a detailed report is a copy of a discharge summary and a bill for $50.00. When this response has been preceded by a professionally demeaning demand for advance payment, the lawyer may conceal his anger for utilitarian purposes, but the damage is done.

As doctors, we are, of course, entitled to a reasonable fee for the time spent in legally related services and should insist that our legitimate fees be paid promptly. Most lawyers readily pay for these services. If copies of discharge summaries or consultation reports are requested, they may be provided at an appropriate fee. Lawyers recognize that both we and our patients have an interest in maintaining the privacy of our personal notes. If we treat the lawyer courteously and supply a report at a reasonable fee, usually he/she will not subpoena our notes.

Most members of the Bar are ethical and as individuals they should be given our respect unless they indicate they are not worthy of it. It is in the interest of both professions and the people we serve for the medical and legal community to cooperate with one another. It is hoped that the joint Physician-Lawyer Liaison Committee can agree on a new set of Principles this year.

Lil James, M.D., Chairman
Physician-Lawyer Liaison Committee

MEDICAL MEETING CALENDAR

JULY

21-25—*Kiawah Island, SC:* **Cardiac and Pulmonary Critical Care Medicine.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

26-28—*Kiawah Island, SC:* **Pediatric Update—1982.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-31—*Hilton Head Island, SC:* **Fifth Annual Symposium on Contemporary Clinical Neurology** (Sponsored by Vanderbilt Univ. Sch. of Med.) Contact Mrs. Joan Sullivan, Dept. of Neurology, Vanderbilt Univ. Sch. of Med., Nashville, TN 37212. PH:615/322-3461.

30-Aug. 1—*Jekyll Island:* **Behavioral Science and Family Medicine Conference.** AAFP prescribed credit. Contact Camille Day, 11 Corporate Square, Ste. 205, Atlanta 30329. PH: 404/321-7445.

AUGUST

2-6—*Hilton Head Island, SC:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

9-11—*Kiawah Island, SC:* **Clinical Obstetrics.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

9-13—*Atlanta:* **Internal Medicine Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

29-Sept. 1—*Knoxville, TN:* **Tri-State Otolaryngology Assembly.** Category 1 credit. Contact Milton G. Yoder, MD, Ste. 204, 501 20th St., Knoxville, TN 37916.

SEPTEMBER

10-12—*Savannah:* **Digestive Diseases: 12th Annual Meeting.** Ga. Gastroenterologic Society. Category 1 credit. Contact Jack M. Averett, MD, 2300 Manchester Expressway, Columbus 31904. PH:404/323-3671.

11-12—*Savannah:* **Cardiac Anesthesia in the General Surgical Patient.** Category 1 credit. Contact William Hammonds, MD, Secy.-Treas., Dept. Anesth., Emory Univ. Hosp., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/329-4603.

15-17—*Savannah:* **Neonatology: The Sick Newborn.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

16-18—*Sea Island:* **Georgia Surgical Society, Annual Meeting.** Category 1 credit. Contact William McGarity, MD, Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, x3322.

24-25—*Unicoi:* **Georgia Rheumatism Society — Annual Meeting.** Category 1 credit. Contact Bill Stokes, Exec. Dir., Arthritis Found., 2799 Delk Rd., SE, Marietta 30067. PH:404/952-4254.

24-26—*New Orleans, LA:* **Southern Medical Association Regional Postgraduate Meeting.** Category 1 credit. Contact Jeanette Stone, SMA, P.O. Box 2446, Birmingham, Al 35201. PH:205/323-4400.

26-30—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

30-Oct. 2—*Savannah:* **Southeastern Allergy Assn.** Contact G. Frederick Hieber, MD, 1401 Monticello Blvd., North, St. Petersburg, Fl 33703. PH:813/525-0861.

OCTOBER

4-5—*Atlanta:* **Contraception: Yesterday, Today, and Tomorrow.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-9—*Hilton Head Island, SC:* **Fourth Annual Frontiers in Nutrition.** Category 1 credit. Contact Jane Greene, Ga. Inst. of Human Nutrition, BD 101, MCG, Augusta 30912. PH:404/828-4861.

14-15—*Atlanta:* **Use and Abuse of Antibiotics—Old and New.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Atlanta:* **The Basic Course on Pain: Diagnosis and Management of Chronic Pain.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-17—*Sea Island:* **Georgia Orthopaedic Society—Annual Meeting.** Category 1 credit. Contact James Averett, Jr., MD, Ste. 2010, 105 Collier Rd., NW, Atlanta 30367. PH:404/355-1798.

15-16—*Atlanta:* **ECG Interpretation & Arrhythmia Management.** Category 1 and AAFP prescribed credits. Internat'l Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

21-22—*Atlanta:* **Cardiology for the Emergency Department Physician.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-23—*Atlanta:* **33rd Annual Meeting, Association of American Physicians and Surgeons: Competition in Medicine — Good or Bad News?** Contact W. Daniel Jordan, MD, 35 Collier Rd., NW, Ste. 385, Atlanta 30367.

29-30—*Atlanta:* **Radiology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

29-31—*Charleston, SC:* **Ambulatory Electrocardiography.** Category 1 and AAFP prescribed credits. Contact International Med., Ed., Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

30-Nov. 2—*Atlanta:* **SMA-MAG Scientific Assembly.** AMA, AAFP, ACEP, and ACOG credit. Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or WATTS line 800/282-0224 (toll-free in Ga.)

Letters to the Editor . . .

Response to the Plastic Surgery Position Statement Published in the February *Journal*

A reply composed by the Executive Council of the Greater Atlanta Otolaryngology — Head and Neck Surgery Society, Albert A. Clairmont, M.D., President. Endorsed by the Executive Committee of the Georgia Society of Otolaryngology, H. Briggs Smith, M.D., President.

Dear Sir:

> *"That I will be loyal to the practice of medicine and just and generous to its members . . ."*[1]

In the February, 1982, issue of the *Journal of the Medical Association of Georgia,* an article appeared, presumably as a position statement of the Georgia Society of Plastic Surgeons, authored by Doctors Rusca and Huger.[2] Appearing to stress the importance of training as a qualification for performing cosmetic surgery, the article was filled with so much misinformation that the specialists in otolaryngology — head and neck surgery felt that the general medical community should be informed of the true facts.

Appearing to stress the importance of training as a qualification for performing cosmetic surgery, the article was filled with . . . much misinformation. . . .

The first bit of *misinformation* was the title,

> "Things are Never What They Seem,
> Skim Milk Masquerades as Cream"[2]

This was claimed by Drs. Rusca and Huger to be a quote from Gilbert and Sullivan's *Mikado;* in fact, the quote is in the *HMS Pinafore* and is as follows: "Things are *Seldom* What They Seem, Skim Milk Masquerades as Cream."

The second bit of *misinformation* was the statement,

> " . . . plastic surgery, which developed from the reconstruction of World War I veteran injuries beginning in 1917 . . . "[3]

The medical literature, however, reminds us that Indian rhinoplastics date back to Vedic times (3000 B.C.), pedicled cheek flaps followed around 600 B.C. by Sushrata Samita, used as a take off from the arm flap reported by Tagliacozzi in 16th century Italy. Frank McDowell, M.D., in his introduction to J.C. Carpue's monumental *Restoring a Lost Nose* (1794), cites this as the "work that represents more than any other book the beginning of modern plastic surgery."[4] Converse credits Rowe (1887), *an otolaryngologist,* as first describing intranasal rhinoplasties, not to mention the more recent work of Sir Harold Gillies, *also an otolaryngologist,* who is recognized as the "Father of Modern Plastic Surgery."[5]

Another bit of *misleading information* was the statement: "Plastic Surgeons who have gone the route of long years of required training" and "years of postgraduate surgical training required for plastic surgery certification."[6] [sic]

More accurately, as summarized in the American Specialty Board Requirements, set up by the Council on Medical Education of the American Medical Association and the American Board of Medical Specialists, there are *five surgical specialties* that require a minimum of *5 years* of residency or other formal training: Otolaryngology — Head and Neck Surgery, (General) Plastic Surgery, Neurosurgery, Orthopedic Surgery, and (General) Surgery. Indeed, residents in otolaryngology — head and neck surgery, although concentrating entirely on the head and neck area in *both functional and aesthetic* capacities, are encouraged to follow their special interests in various subdivisions including otology, bronchoesophagology, allergy, head and neck and facial plastic and reconstructive surgery, etc.

The general medical community may be pleased to know of the far more stringent requirements for membership in the American Academy of Facial Plastic and Reconstructive Surgery, Inc., as compared with the American Board of Plastic Surgery.

Another bit of *misleading information* was the statement: "The American Academy of Facial Plastic and Reconstructive Surgery, Inc. . . . Appear(s) to be (a) *splinter group* of the otolaryngology fraternity" . . . whereas the "American Board of Plastic Surgery was born as a *subsidiary* of the American Board of Surgery."[7]

The general medical community may be pleased to know of the far more stringent requirements for membership in The American Academy of Facial Plastic and Reconstructive Surgery, Inc., as compared with the American Board of Plastic Surgery. Board certification in (General) Plastic Surgery, as adopted from The Directory of Residency Training Programs, requires a minimum of 3 years of training in general surgery (or Board Certification in orthopedic surgery, urology, or otolaryngology — head and neck surgery) as their core curriculum, followed by training in (general) plastic surgery for 2 years. The candidate may or may not have to submit lists of operations for 1 or more years, at the discretion of the Board.

Then he must pass the written and oral examination, included in which are eight detailed cases presented by the candidate (and selected by the candidate, to include or not to include head and neck procedures). If he completes the oral and written parts of the examination successfully, he becomes a Diplomate of the American Board of Plastic Surgery.

. . . as summarized in the American Specialty Board Requirements . . . there are five surgical specialties that require a minimum of 5 years of residency or other formal training. . . .

Fellowship in The American Academy of Facial Plastic and Reconstructive Surgery, Inc. however, requires the surgeon to be

"(a) A Diplomate of the American Board of Otolaryngology or its equivalent (American Examining Board of Specialists)
"(b) A Fellow of The American College of Surgeons
"(c) Trained and experienced in plastic and reconstructive surgery of the head, face, and neck and shall actively have been engaged in such practice for 3 years prior to application to be eligible for membership status"[8]
"(d) The candidate for fellowship must submit to the Secretary a detailed report of 35 major surgical procedures performed by him relative to his field and a list of all surgical procedures performed in the year prior to his application."[9]

Another bit of *misguided conclusion* was the statement: " . . . excellence in the aesthetic element is *built in* to his (general plastic surgeon's) training, and the necessity for its inclusion over a minimum 2-year period has been proven *without question* in the opinion of parent certifying agencies."[10]

If a general plastic surgeon proclaims supreme excellence over all other specialties after only 2 years of diluted training in the broad scope of general plastic surgery (head and neck, upper extremity, trunk, lower extremity, and genitourinary system[11]), should not his training be as concentrated as all these specialties? If this were the case, then a true purist of general plastic surgery who schedules in 1 day a blepharoplasty, a septorhinoplasty, a mandible fracture repair, a hand procedure, and a mammoplasty, should have had a minimum of *15 years* of post general surgery training!

In all seriousness, and with gentlemanly professionalism, misinformation must be corrected with facts, misleading statements must be clarified, and controversy must be kept in its place. Obviously, there exists no specialty that can claim supreme excellence over other practitioners of the same art; experience and expertise are horizoned only by the self-limitations of the individual practitioner of his own art. Respect and friendships cross many specialties, perpetuating the oath we all took when we received the privilege to practice our art. . . .

> *"I do solemnly swear, by whatever I hold most sacred: That I will be loyal to the practice of medicine and just and generous to its members. . . ."*[1]

References

1. The Hippocratic Oath.
2. Rusca JA, Huger WE, Jr. "Things are never what they seem, skim milk masquerades as cream." J Med Assn GA 1982;71:103.
3. *Ibid,* 104.
4. Carpue JC. An account of two successful operations for restoring a lost nose from the integuments of the forehead. In, Classics of Medicine Library, 1981, Birmingham.
5. Converse JM (ed). Reconstructive Plastic Surgery, Vol. 1. Philadelphia. Saunders, 1977, p. 21.
6. Rusca JA, Huger WE, Jr. *Op Cit,* 103, 104.
7. *Ibid,* 103, 104.
8. American Academy of Facial Plastic and Reconstructive Surgery, Inc. By-Laws, p. 5.
9. American Academy of Facial Plastic and Reconstructive Surgery, Inc. General information and information for applicants, pp. 3-4.
10. Rusca JA, Huger WE, Jr. *Op Cit,* 104.
11. Directory of Residency Training Programs, Part II. Special Requirements, p. 474.

Reader Responds to June "Legal Page"

Dear Sir:

The article, "Physicians as Witnesses — Rights, Obligations, and Reasonable Compromise" [June *Journal,* "Legal Page," pp. 433-436], by F. C. Schenck is very timely and does an excellent job of pointing out the physician's duties to his patient in regard to civil litigation. There are two points, however, which should be made clear.

First, the physician, like any other expert witness, is entitled by Georgia law to a reasonable fee for his time as an expert witness (Ga. Code Ann. Sec. 81A-126(b)-(4)(A). This is in addition to the statutory fee of $10.00 plus mileage. Such a fee is collectable in a court of law after the service is rendered. No "advance fees" are legally collectable, and no physician can legally refuse to testify because an expert witness fee has not been paid.

Second, while the patient may "waive privilege" when he "files suit," he waives privilege only to that medical information related to the issues in his suit. He does not waive confidentiality to any medical information. The law requires that patient information be released only with the patient's consent or by valid court order or subpoena. Medical ethics has always placed great emphasis on the right of privacy, and our patients and their attorneys expect us to respect this right.

Sincerely,
Lil James, M.D., Chairman
MAG Physician-Lawyer Liaison Committee

An Open Letter to Physicians

As the practice of medicine has become more complex and specialized, the medical assistant has become the physician's most valuable allied health professional — and the American Association of Medical Assistants (AAMA) has become organized medicine's best ally. The professional development offered to its members by AAMA can make the difference between an amateur and a professional office staff.

Professional medical assistants are committed to self-development and lifelong learning. They are concerned not only with earning a living but also with serving patients.

Qualified medical assistants can perform many administrative, clinical, managerial, and supervisory functions, freeing the physician to spend more time in direct patient contact. AAMA is dedicated to the education of this multi-skilled professional.

AAMA recognizes that competence in the field requires medical assistants to communicate effectively, adhere to ethical and legal standards of medical practice, respond to medical emergencies, and demonstrate professional characteristics. In response to increased patient awareness and technologic advances, medical assistants, through AAMA, have assumed more responsibility for patient care tasks.

Medical assistants are the first and last health care professionals to see the patient in the office. They are in a unique position to reflect the philosophy of the office and set the tone for everything that happens there. The medical assistant's impact on a physician's success and efficiency may be even greater than he realizes, for it is the medical assistant who bridges what some have called the greatest communication gap in our society — that between the physician and his/her patients.

AAMA is attuned to the problems of modern medical practices. AAMA realizes practices that fail to treat today's patients with dignity and respect are in for a rude awakening.

Malpractice suits in all areas of health care are increasing. The majority of these suits arise from misunderstanding — real or imagined slights and neglects. A patient is less likely to file a suit against an office where he feels he has received professional, just, and courteous treatment.

As agents of physicians, medical assistants should be thoroughly versed in medical law and ethics as they apply to the physician-patient and the medical assistant-patient relationship.

Commitment to high standards in certification, accreditation, and continuing education is the hallmark of AAMA's professionalism. The three educational arms of AAMA — Certifying, Continuing Education, and Curriculum Review Boards — work constantly to help members increase their competence and the quality and scope of their services. AAMA offers organized educational activities, planned meetings, study groups, continuing education programs and workshops to broaden members' knowledge.

AAMA was organized in 1956; its primary objective is professional self-improvement, to enable each medical assistant to better serve the medical profession and the public. AAMA inspires its members to give honest, loyal, and efficient service, to improve their educational background, and to better serve their employers. It is to the physician's advantage to encourage AAMA membership.

Physicians depend upon medical assistants to manage their offices competently and efficiently. AAMA's potential membership is estimated at 300,000-500,000 members, yet its current membership is less than 16,000. With AAMA as its representative, medical assisting as a whole could be the strongest and most important allied health profession to physicians.

According to its bylaws, AAMA is not, nor can it ever become, a union or collective bargaining agency. In addition, the association has been commended by the American Medical Association on six separate occasions.

For further information, I encourage you to contact your state medical society or write to the American Association of Medical Assistants, One East Wacker Drive, Suite 2110, Chicago, Illinois 60601. The investment of your time today can result in physicians, medical assistants, and patients *all* benefiting as AAMA helps its members fulfill their professional obligations.

Ralph E. Hagan, M.D.
Vice-Chairman
AAMA, Physician Advisory Board

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J-9043-4 July 1981



In the treatment of insomnia

Good mornings start with restful nights.

Dalmane *(flurazepam HCl/Roche)* patients fall asleep faster, sleep longer and seldom awaken with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.[1] In a double-blind crossover study of 42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.[2] This difference was highly significant ($p<0.001$). And a retrospective study of 254 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.[3]

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturna awakenings.[4] The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.[5-8] Since the risk of oversedation, dizziness, confu-

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sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.[1] Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.[9,10] However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.[11] When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: **1.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **4.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Meyer JA, Kurland KZ: *Milit Med 138*:471-474, Aug 1973. **6.** Feffer HL, Gibbons B: *Med Times 101*(8):130-135, Aug 1973. **7.** Jacobson A *et al: Psychophysiology 7*:345, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 1978. **10.** Kales A *et al. JAMA 241*:1692-1695, Apr 1979. **11.** Monti JM: *Methods Find Exp Clin Pharmacol 3*(5):303-326, 1981.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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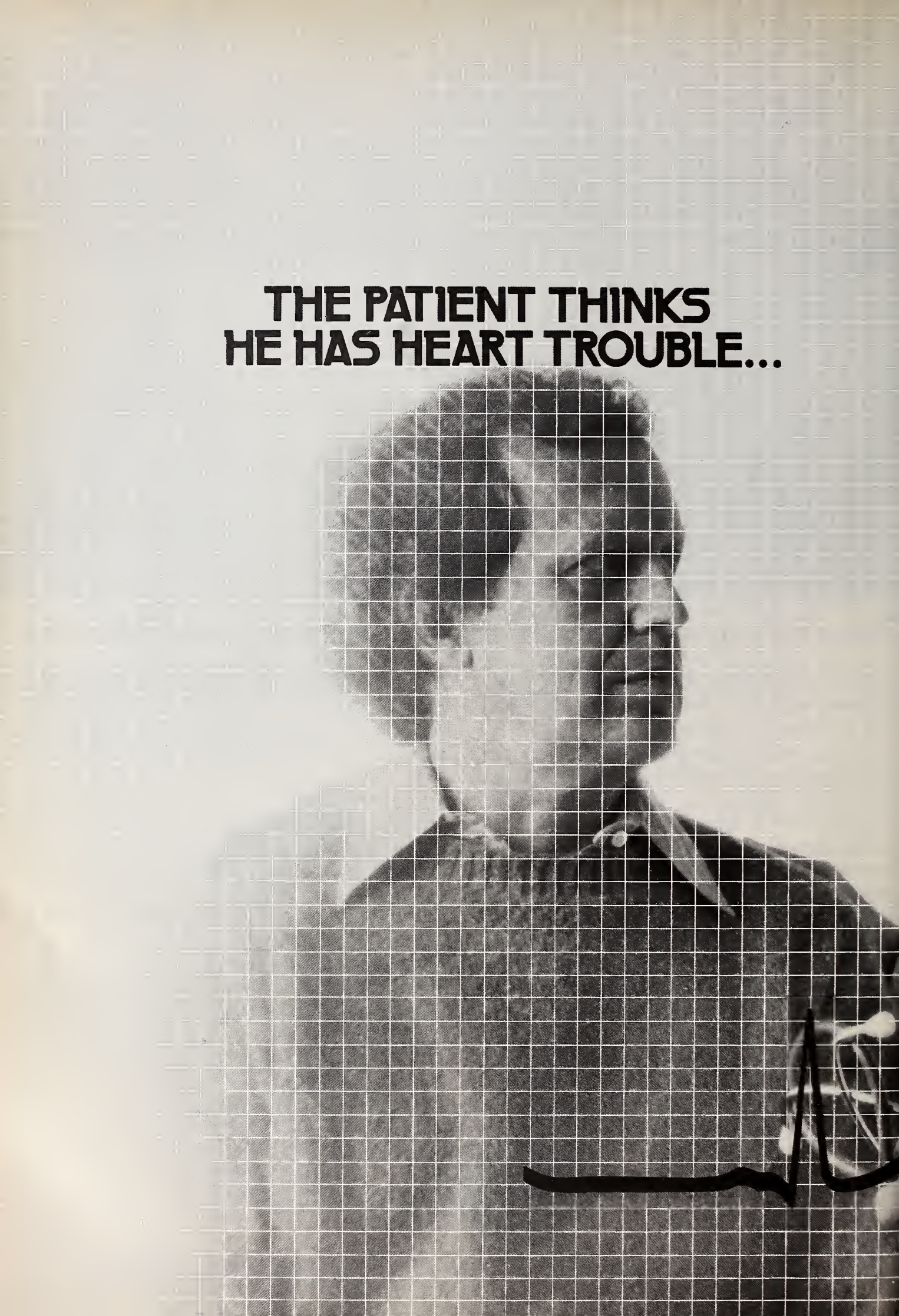
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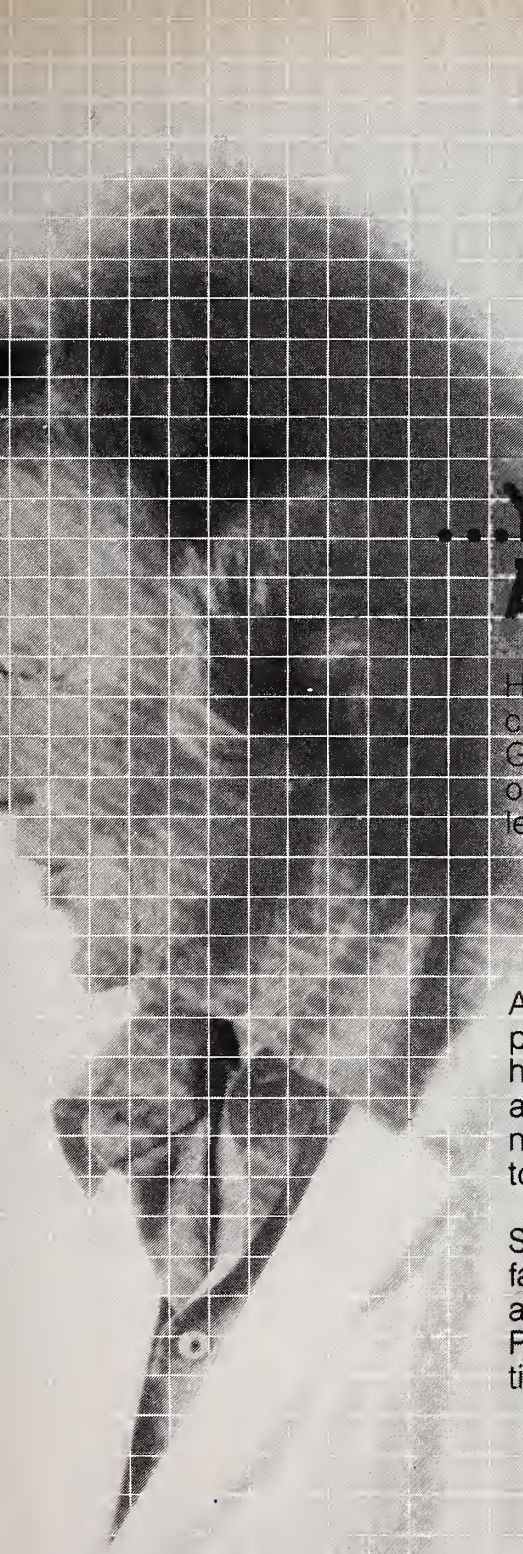
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation. slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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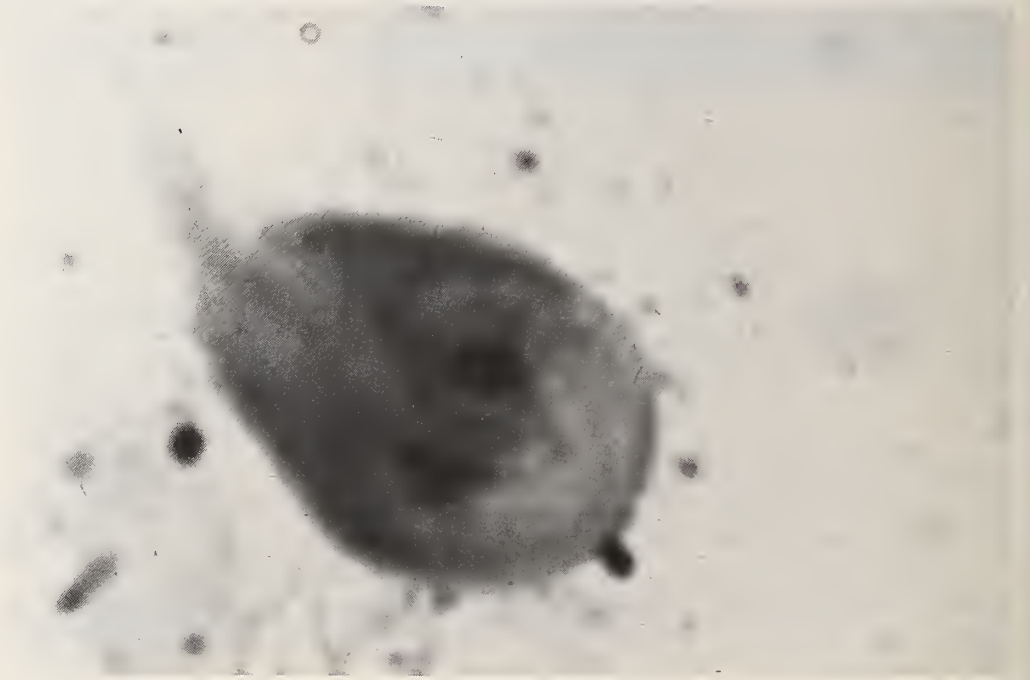
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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

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Roentgen Cephalopelvimetry — Genetic Acceptability and Medical Efficacy

RUSSELL E. WIGH, M.D., and C. I. BRYANS, JR., M.D., *Augusta**

Abstract

Selective roentgen cephalopelvimetry at term is an asset in the proper conduct of labor. A summation of individual case studies indicates that the examination can have a high medical efficacy. With new techniques, the gonadal dose in vertex presentations is less than the yearly dose from cosmic and terrestrial radiations. There is no proof that such cephalopelvimetric portals limited to the maternal pelvis are carcinogenic or productive of genetic harm to the fetus.

An erroneous film interpretation leads to long delays in decision making after roentgenograms have been obtained for bony dystocia. This observation may explain why a massive statistical survey led to a claim that cephalopelvimetry does not shorten labor in cases needing surgery.

Between 1943 and 1977, over 150 articles about cephalopelvimetry were listed in the Cumulative Indices of the journal, *Radiology*.[1] There were 40 in the first 5 of those years, and one in the last 5 years. The reduction in the use of this procedure is as impressive as the reduction in the number of publications. Indeed, there may be too prominent a shift away from its use.

* Dr. Wigh is Professor Emeritus of Radiology, and Dr. Bryans is Professor of Obstetrics and Gynecology, Medical College of Georgia. Send reprint requests to Dr. Wigh at the Department of Radiology, Medical College of Georgia, Augusta, GA 30912.

In our institution, the peak incidence for the examination between 1971 and 1978 was reached in 1973; cephalopelvimetry was obtained 219 times among 1,345 patients (16.3%). Reductions occurred subsequently and by 1978, among 1,880 parturients, the maternal pelvis was exposed for radiography 74 times (3.9%). Improvement in our application of Friedman's principles[2, 3] regarding abnormal labor patterns is expected to reduce the incidence even further.

A precipitous decline occurred in 1974. It is probable that advances in the use of electronic monitoring was partially responsible for this decline, but it is more likely that an increased national awareness of potential harmful genetic and somatic effects of x-ray exposures was the greater factor. The reduction was not due to ultrasonography, since this procedure was not used in the actual conduct of labor at term.

In 1975, a statistical report covering 67,078 single deliveries was published by Kelly and his associates.[4] Of these pregnant patients, 4,599 (6.9%) had had roentgen cephalopelvimetry. At one of the 16 cooperating hospitals, the rate reached 15.7%. The report concluded that the procedure had little or no value for enhancing physician confidence that cesarean section would not be necessary among patients with normal pelvises. Further, the authors claimed that the duration of labor was not significantly altered in cases needing surgery for disproportion.

Recently, Campbell[5] discussed the efficacy of pelvimetry. He stated that the Martin Luther King Hospital had had an "incidence of ordering pel-

vimetry of 18.5%'' but that in 2,000 recent deliveries, not a single pelvimetry was performed. Among these, there was no evidence of fetal or maternal morbidity. One applauds the demise of his 18.5% and our 16.3% usages, but we do not concur that the procedure has no merit.

Our improved selectivity permits a more precise efficacy evaluation; and this can be identified from a summing of individual patient appraisals. Were a risk-free procedure with great cost effectiveness and modest medical efficacy available, one should conclude that such an examination should be appropriately pursued.

Cost Effectiveness

During 1977 and 1978, 175 cephalopelvimetries were obtained preceding 3,859 deliveries. The combined professional and hospital delivery charges were $3,473,000. The roentgenologic fees (technical and professional) were $7,982, raising the average cost per patient from $900 to $902.04.

Medical Efficacy

This objective was sought from analyses only of those 90 medical records containing a discharge diagnosis of cephalopelvic disproportion (2.3%). The review was limited to those 2 years, 1977 and 1978, in which the number of associated cephalopelvimetric examinations was the lowest (4.5%).

The roentgenograms consisted of either a maternal inlet view (Torpin[6]) or, more frequently, that film combined with a lateral one. Among the 90 cases, roentgen cephalopelvimetry was obtained 57 times, 56 of them during labor.

Eighty-three patients were at a first test of labor for a term pregnancy, the remaining seven having had previous live births vaginally. Eighty-seven had cesarean sections. Two infants with hydrocephaly were delivered after ventriculocentesis and one by forceps.

When one averages the hours of labor for the 90 patients, that average approaching 20, it is not greatly in excess of the maximum for uncomplicated vaginal deliveries. But this figure conceals the many patients with very protracted labors, and in this surgically delivered group, all of this labor is useless beyond that time considered to be an adequate ''test of labor.''

Of the total, 83 patients at admission were found to have the presenting part at or above the spines (Table 1). In 57 recorded instances, the fetal head station remained at those positions as judged manually, with an average length of labor of 20.9 hours. This is truly a lengthy test of labor!

Head circumferences at birth, excluding hydrocephaly, fell within the measurement for the norm, but there were some which reached 38 cm.

TABLE 1 — Patients with Discharge Diagnosis of Cephalopelvic Disproportion

	With Pelvimetry	*Without Pelvimetry*	*Totals*
Number of Patients	57	33	90
Ages:			
17 yrs. or less	27	8	35
Maximum	30	38	—
Minimum	13	12	—
Presentations:			
Vertex	55	31	86
Breech	2	2	4
Clinical Stations			
At admission			
Above or at spines	54	29	83
Below spines	3	3	6
Not recorded	0	1	1
Final			
Above or at spines	42	15	57
Below spines	11	14	25
Not recorded	4	4	8

TABLE 2 — Mensurations

	With Pelvimetry	*Without Pelvimetry*	*Totals*
Number of Patients	57	33	90
Manual pelvimetry			
Not performed or not recorded	5	5	10
Assessed normal	25	14	39
Misinformation, % of	48.1	50	48.8
Assessed borderline or contracted	27	14	41
Roentgen cephalopelvimetry			
Not performed	—	33	33
Performed	57	—	57
Percent of total deliveries	1.48		
Hours before delivery			
Average	7.3		
Minimum	2.0		
Maximum	19.0		
Number of patients delivered 5 or more hours after roentgenography	35		

Oxytocin was administered to 54 of these mechanically obstructed patients; labor averaged 18.2 hours. When not used, labor averaged 10 hours. This extension of labor occurred in both the pelvimetry and non-pelvimetry subgroups.

Labor was needlessly prolonged when roentgen data were available but were not used. Between the activities of radiologic assessment and cesarean section, the general period of time was 7.3 hours; the maximum delay in the application of available information was 19 hours (Table 2). Kelly's statistical report[4] mentioned that a delay for the procedure should be about 1 hour (for patient transport and the technical procedure combined).

Perhaps misinformation from *manual* pelvimetry led to some prolongation of labor; 48.8% of the pelvises were judged as normal (Table 2).

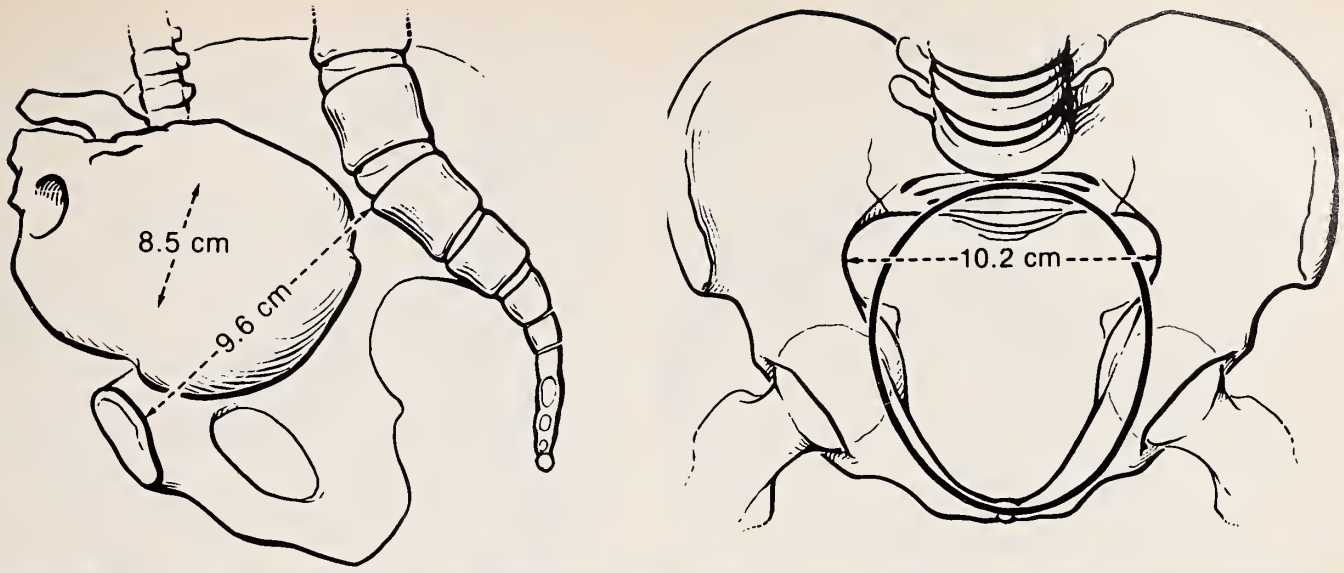


Figure 1 — Case I — (Left) Bilateral acetabular intrusions narrowing the anterior aspect of the inlet of the maternal pelvis. (Right) Fetal head position is occiput posterior; head is molded even though unengaged.

Almost twice as many newborns had an Apgar score of 5 or below at 1 minute in the non-cephalopelvimetry group (7 of 31 live births) as did those in the pelvimetry group (7 of 57).

Report of Cases

Case I — A 13-year-old primigravida entered the hospital at 37 weeks of gestation with mild toxemia. Labor began spontaneously. On admission to the labor room her cervix was 6 cm dilated with the head unengaged. After a labor there of 14.75 hours, enhanced with 2 hours of oxytocin, the cervix had dilated to 8 cm. The station of the vertex never advanced to lower than −3 cm. Cephalopelvimetry was performed 9.75 hours after admission. The patient was delivered of a 2940 gram infant by cesarean section. Apgar scores were 8 and 9. The head circumference was 34.5 cm. The films (Figure 1 left & right), taken 5 hours before delivery, showed that the transverse diameter of the inlet measured 10.2 cm, but a bilateral intrusion acetabulae narrowed the anterior inlet to 7.8 cm. The anteroposterior diameter was 9.6 cm. The fetal occipitobregmatic diameter was 8.5 cm. The occiput was posterior (this had not been determined manually). Even though yet unengaged, the fetal parietal bones protruded a cm from normal skull contour.

Comment: The deformed pelvis could not possibly accommodate the average-sized fetal head. Oxytocin was contraindicated. The station was factually higher than by physical examination. Clinical pelvimetry gave grossly false information (recorded as "normal"). Roentgenograms should have been taken when the patient was transferred to the labor room.

Case II — A 17-year-old primigravida patient at term was admitted with ruptured membranes 1 hour after the onset of labor. The cervix was 1 cm dilated. During the next 25 hours of labor, its intensity progressed from 1+ to 4+ and the cervical dilation to 8-9 cm. Oxytocin was administered for 12¼ hours. The admission station of the head was variably described as from −2 to 0. The final station was recorded as −1. The roentgenograms were taken 15 hours after admission and 10 hours before delivery. The infant, delivered by cesarean section, weighed 2890 grams and had a head circumference of 35.5 cm. Apgar scores were 9 and 10. Even though the head was unengaged, the films demonstrated marked molding, the parietal bones protruding about 1.5 cm distally to the projected curve of the occiput; the greatest skull diameter was still far above the plain of the inlet (Figure 2). The measurements were: occipitobregmatic, 9.8; anteroposterior of the inlet, 10.6 cm; transverse of the inlet, 11.2 cm.

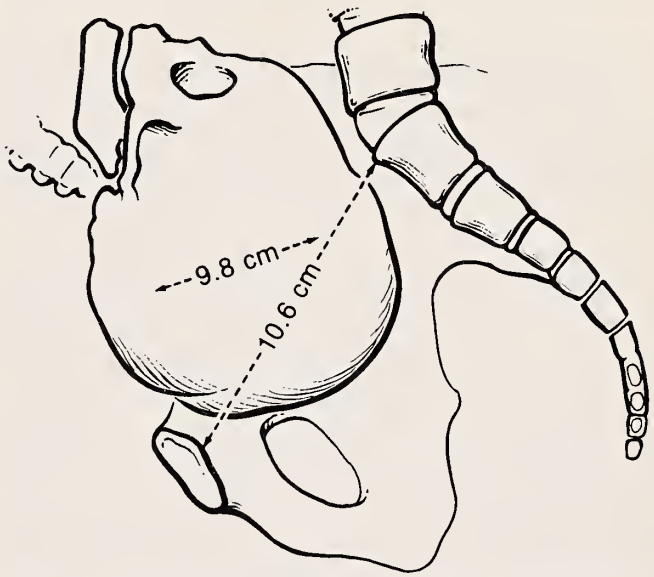


Figure 2 — Case II — Fetal head molding 10 hours before surgical delivery.

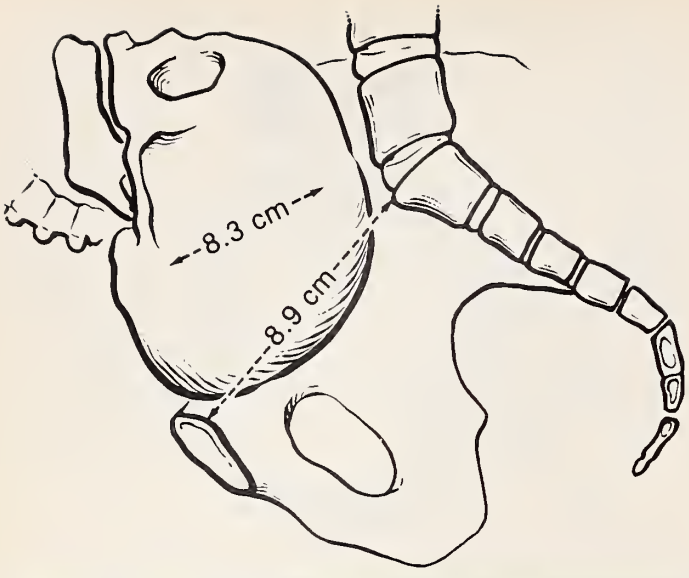


Figure 3 — Case III — Lateral examination of a platypelloid pelvis with a sagittal diameter of 8.9 cm.

Comment: Manual judgment of station was incorrect; roentgenograms were taken too late; delay after filming was excessive. The use of oxytocin was contraindicated at least for the 5.5 hours after the films were obtained. Clinical analysis of pelvic size was incorrect, being recorded as "adequate."

Case III — A 19-year-old primigravida entered the hospital at term with a history of labor for the previous 8 hours. The cervix was 1.5 cm dilated. The station of the presenting vertex was at −3 cm. Roentgenograms were taken at admission. Clinical pelvimetry was not recorded. The patient was delivered by cesarean section of a 3600 gram baby 2¾ hours after admission, Apgar scores being 8 and 9. The films demonstrated a sagittal diameter of 8.9 cm (Figure 3) in a platypelloid pelvis having a transverse diameter of 11.7 cm. However, the occipitobregmatic diameter was 8.3 cm. The maternal sacrum was flat. The side walls converged toward the outlet indicating a worsening pelvic form below the inlet. The unengaged head was nearly 6 cm above the ischial spines.

Comment: The roentgenograms, employed promptly, were an aid in this delivery.

Case IV — A 27-year-old patient entered the hospital after 45 minutes of labor considered as of 3+ intensity. Cervical dilation was 3 cm. Previously, she had delivered a 2100 gram infant. A frank breech presented now at 37 weeks. After 6 hours of labor, roentgenograms were taken. After a total of 9 hours of labor, the cervix had dilated only to 4 cm. A 2620 gram infant was delivered by cesarean section, head circumference 33 cm, Apgar scores being 9 and 9. The films had indicated that the aftercoming head was within normal limits of size. The anteroposterior pelvic diameter was 11.4 cm (Figure 4 left) but the forepelvis was severely android (Figure 4 right) reducing a measured transverse diameter of 10.6 cm significantly.

Comment: Films should have been taken earlier and the information used more promptly. The small transverse pelvic size and the severely android character of the forepelvis introduced a significant hazard for vaginal delivery of a fetus presenting by the breech.

Case V — A 14-year-old primigravida entered the hospital with a history of 12 hours of labor. At admission, the contractions were recorded as 3+ intensity. The cervix was dilated to 2 cm. After a further 17.75 hours of labor, including enhancement with artificial rupture of the membranes and two hours of oxytocin infusion, the cervical dilation reached only to 5 cm. The vertex station at admission was − 4 cm. Manual estimation of the pelvis had been considered borderline. Roentgenograms

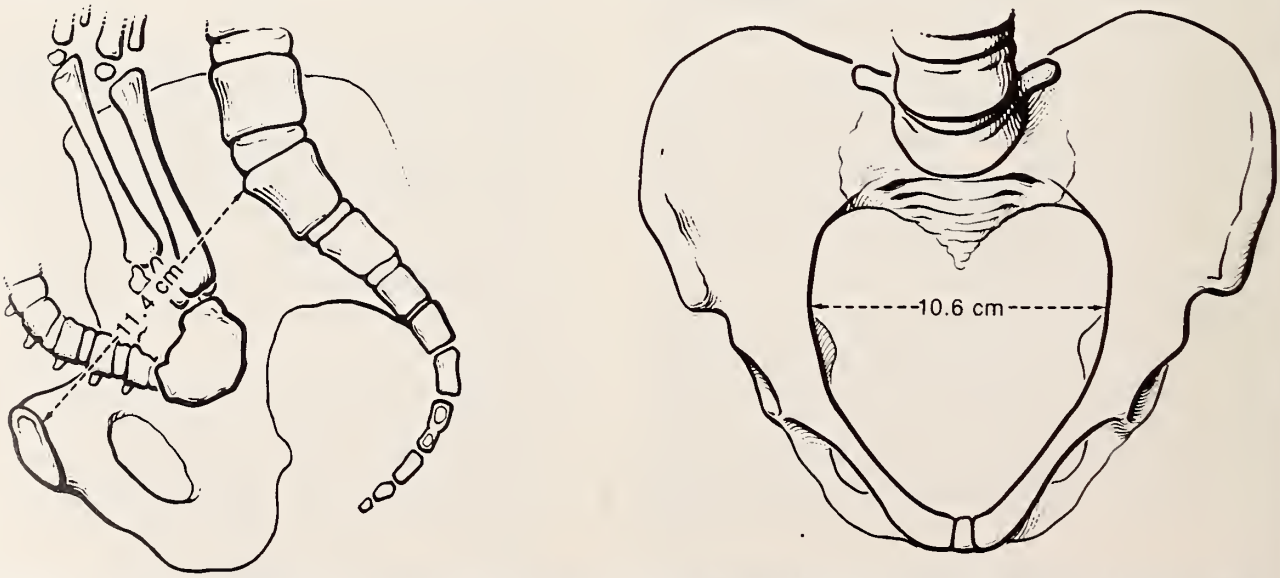


Figure 4 — Case IV — (Left) Lateral view, frank breech. (Right) Severely android forepelvis narrowing the available inlet for aftercoming head.

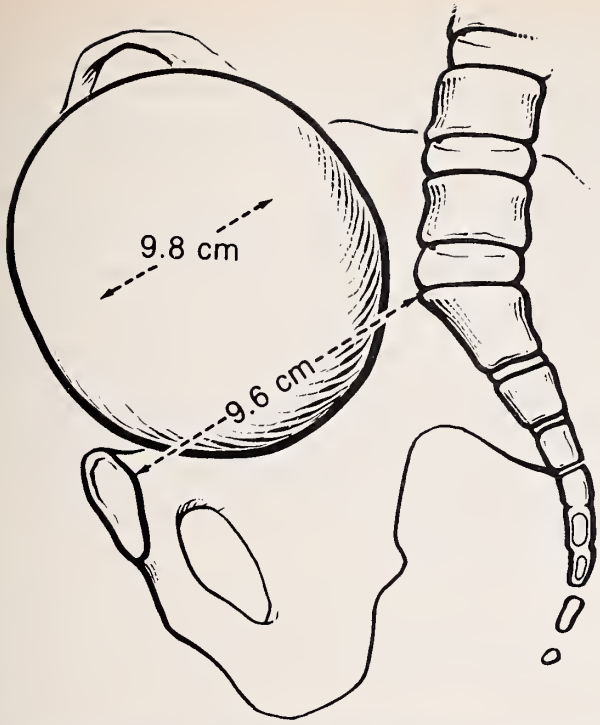


Figure 5 — Case V — Fetal biparietal diameter is 9.8 cm. Sagittal pelvic diameter is 9.6 cm. The skull overrides the symphysis.

were obtained 7 hours after admission, labor then of 19 hours length, but the data were not appropriately used, and labor continued for another 10 hours. At cesarean section, a 3110 gram infant with a head circumference of 35 cm was delivered; Apgar scorings were 3 and 7. The infant was admitted to the intensive care unit. The films showed that the biparietal diameter was 9.8 cm, the sagittal pelvic diameter was 9.6 cm, and the transverse diameter 10.9 cm. The station of the unengaged head was −5 cm. The lateral film (Figure 5) showed that although one parietal bone was close to the promontory, the other overrode the symphysis.

Comment: Although the history of 12 hours of labor before admission may have been inaccurate, the in-house labor of 10 hours following the roentgenograms was fruitless. Oxytocin was contraindicated.

Case VI — A 17-year-old primigravida, at 40 weeks gestation, had labored for 5 hours prior to admission. Cervical dilation was 3 cm. Labor was enhanced by artificial rupture of the membranes and with 7 hours of oxytocin infusion. The admission station of the presenting vertex was −1 to −2 cm. The final station after a total of 24.5 hours of labor was recorded as station 0. The infant, delivered by cesarean section, weighed 3300 grams. The head circumference was 35.5 cm. Apgar scores were 9 and 9. Clinical pelvimetry was recorded as "all measurements small." Roentgenograms (Figure 6 left & right) were obtained 19 hours before surgery. The biparietal diameter was 9.1 cm; the anteroposterior inlet measurement was 9.6 cm; the transverse pelvic diameter was 11.2 cm. The forepelvis was android. All four walls converged toward the outlet. The sacral concavity was minimal. One fetal parietal bone was abutting against the upper sacrum. The contralateral parietal bone overrode the tangent of the inner aspect of the pubis.

Comment: The patient should have undergone a cesarean section 19 hours earlier, immediately after the films. Oxytocin was contraindicated. It is doubtful that the true final station was 0.

Similar analysis of the remaining cases, all surgically treated for bony disproportion, indicated to us that were the obtained roentgenograms optimally employed in each case, they would have been helpful in 41 of the 57 cases; that in the 33 cases not having the examination, cephalopelvimetry might have been helpful in 17 instances (Table 3).

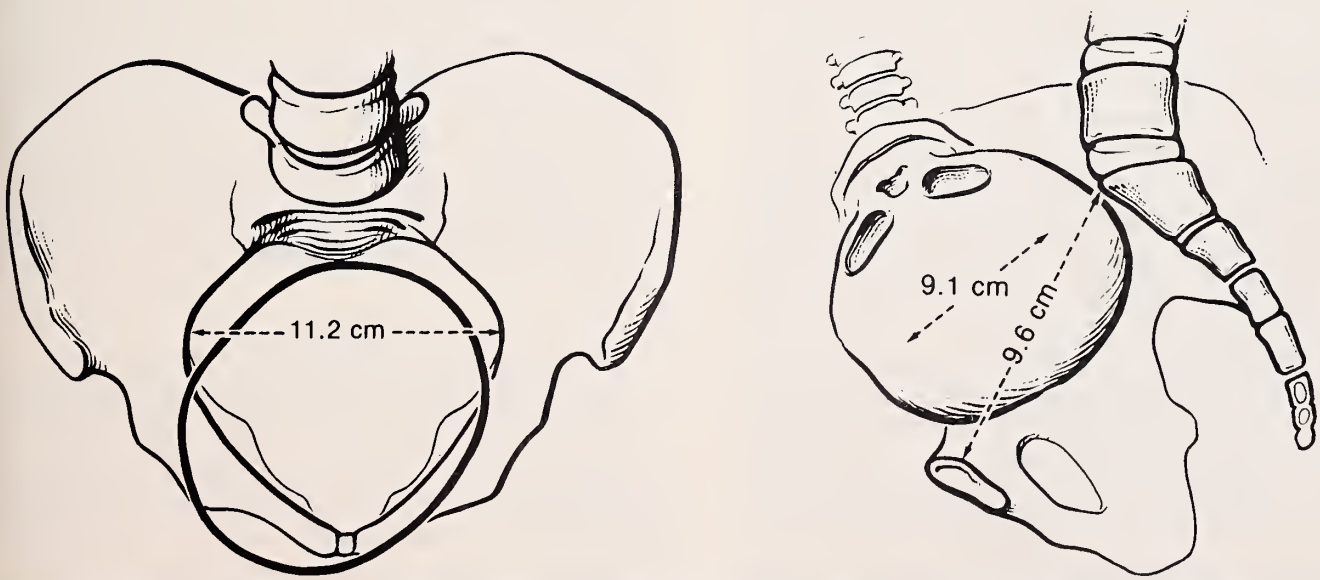


Figure 6 — Case VI — Roentgenograms obtained 19 hours before cesarean section. (Left) Small platypelloid-android pelvis with converging sidewalls. (Right) Convergence of anterior and posterior walls toward the outlet. Skull overrides pubis.

Radiobiologic and Technical Considerations

Assuming concurrence about cost and medical efficacy, should we perform germ-cell harmful or carcinogenic procedures except under extraordinary circumstances? On the basis of our technical advances readily put into service, we do not believe that the question has any relevance.

The alarm, announced in 1958, regarded a somatic effect, the induction of cancer in children from maternal irradiation during pregnancy.[7, 8] Presently, there is no longer certainty as to the reliability of those findings; among 1250 Japanese children exposed in utero to up to 500,000 millirad from atomic bombing, no excess cancer deaths were observed. According to risk estimates, 5.2 excess deaths should have been found by age 10.[9]

Concerning fetal gonadal dose in vertex presentations, a proper perspective is obtained by comparing that small quantity of secondary scatter of x-rays from limited pelvic portals which reach the fetal reproductive organs to cosmic radiation and other natural radiations. In the mountainous states, particularly, the dose to which the fetus is exposed, much of it during the critical periods of organogenesis, reaches as high as 220 mrad per year from terrestrial and cosmic radiations.[10]

Ideally, this roentgen examination should be applied in that period of labor when Friedman's labor curves indicate the presence of an abnormal pattern, notably arrest of or protracted descent of the fetal head.

Fetal gonadal doses, in four of our new techniques, are below 15 mrad for combined sagittal and lateral projections limited to the maternal pelvis, when the fetal head is presenting. The measurements were made in a plastic abdominal phantom built up with paraffin to an anteroposterior diameter of 25 cm and contoured to simulate the pregnant state. The central ray was perpendicular to the maternal axis. This dose is far below the 80 mrad/year to the gonads from various sources of natural background radiation in the United States.[11] It can be compared with surface doses of 7 mrad per year received by persons living in houses built with brick or masonry structural materials; and it must be compared with gonadal doses experimentally obtained in the same model, but using our previous techniques. These reached up to 3613 mrad. When the central ray was along the axis of the fetus, as it is in an inlet view, an astounding dose of 21,900 mrad reached the genital area.

A variety of technical combinations were tested. Those four with the lowest doses were of a quality acceptable to our radiologists and obstetricians. The essential elements are: 120 kvp, small fields (25 × 30 cm), and rare earth screens. A further slight decrement (several mrad) was found by using high-speed green sensitive films, by increasing the tube-film distance from 40 inches to 72 inches, and by substituting stationary grids for the moving grids in Bucky apparatus. These should not be considered as obligatory adjuncts; indeed, a 72-inch requirement is difficult to meet in some radiographic rooms.

No attempt should be made to persuade physicians to abandon the procedure any more than a policy should declare that the mountainous states be off limits to the pregnant woman.

Background radiation is continuous and therefore is fractionated over 280 days, in contrast to the milliseconds of exposure during roentgenography. The biologic effect of cosmic gamma radiation also differs from that of 120 kvp x-rays. However, there is no reason to assume that the relative biologic effects of the two differ by more than a factor of two. The doses, therefore, with these newer techniques still are far below that of average background, and are delivered at the time of maximal fetal development.

Support for the argument that this helpful examination is genetically and somatically acceptable is obtained from the recent report of the new committee on the Biological Effects of Ionizing Radiations (BEIR III).[9] This committee found no proof that dose rates of gamma or x-rays of about 100 mrad per year are detrimental to man; the members conclude that any somatic effects at this dose would be masked by environmental or other factors that produce the same type of health effects as does ionizing radiation; that it is unlikely that carcinogenic and teratogenic effects of such doses will be demonstrable in the foreseeable future; that it is likely that there are threshold doses for most maldevelopments; and that lowering of dose rates diminishes damage. The committee specifically cautions that linear extrapolation from high absorbed doses is likely to result in overestimates of the risks of low absorbed doses.

Comment

There has been an appropriate local and national reduction in the numbers of cephalopelvimetry examinations. However, there is no radiobiologic or medical practice warrant to totally discontinue such studies. No attempt should be made to persuade physicians to abandon the procedure any more than a policy should declare that the mountainous states be off limits to the pregnant woman.

Unless manual pelvimetry is done by an expert physician who is capable of both sizing and typing a pelvis, the appraisal has more potential for harm by yielding misinformation than for good. Errors in digital assessment of head station were more notable when the head was unengaged. The accumulated data suggested that when the forces of labor and skull molding had permitted the vertex to reach to the ischial spines or slightly below, the patient was less likely to have cephalopelvimetry. Among patients not x-rayed, 11 of 26 made such progress. Among those with the x-ray examination, only eight of 51 heads descended below the spines.

Although it is not clear whether labor is prolonged in cases of cephalopelvic disproportion because oxytocin was used or whether the test of labor would have been excessive anyway, it is evidently valueless as soon as a diagnosis of disproportion can be reached. It should not be used if bony disproportion is under consideration.

Table 3 does not support a statistical contention[4] that the use of the procedure will fail to assist in the management of labor. Six cases of the 41 have been presented. Any bias would be similar among the 35 others.

The table includes an assessment of the errors in the conduct of labor, exclusive of oxytocin usage. In each subgroup, the error rate approximates 50%. Statistically, one could claim that since the performance rates are the same, the procedure has no merit. Such an analysis overlooks that there were three additional and determinable parameters in the examined subgroup: delay in obtaining the films, incorrect evaluations of them, and inordinate periods of time between roentgenography and operative delivery.

Ideally, this roentgen examination should be applied in that period of labor when Friedman's labor curves[2] indicate the presence of an abnormal pattern, notably arrest of or protracted descent of the fetal head. Cephalopelvic disproportion will be found roentgenologically in about 50% of such cases.[3] In this group, this algorithmic approach should initiate prompt cesarean section. For nearly all of the parturients in the remaining half, it will lead to conservative management, reducing the incidence of abdominal surgery.[3]

An efficacy rating for cephalopelvimetry can be estimated in three different ways. In this sample, for patients having the procedure appropriately used as well as having a final diagnosis of disproportion, 41 of 57 would have been helped (71.9%); or, for the patients who had bony dystocia, the management of labor would have been improved in 41 of the 90 cases (45.6%); or, of the 175 patients having the procedure within a 2-year period, 41 would have been aided (23.4%). To select this last rating, one must assume that a knowledge that bony disproportion is not the cause of dystocia is of no medical value.

TABLE 3 — Evaluations Concerning the Conduct of Labor in 90 Patients

	57 Patients Having Cephalopelvimetry			*33 Patients Without Cephalopelvimetry*		
	Yes	No	Indeterminate	Yes	No	Indeterminate
Roentgenography helpful, optimally used	41	5	11	—	—	—
Roentgenography potentially helpful	—	—	—	17	12	4
Errors in conduct of labor	28	25	4	17	14	2
Misuse of oxytocin	17	16	2	5	11	3

Cephalopelvimetry, an examination performed with ease, can have a high degree of accomplishment; and when properly performed technically, has no greater genetic or somatic risk than cosmic radiation. It is not to be abandoned because of physician error.

Acknowledgments

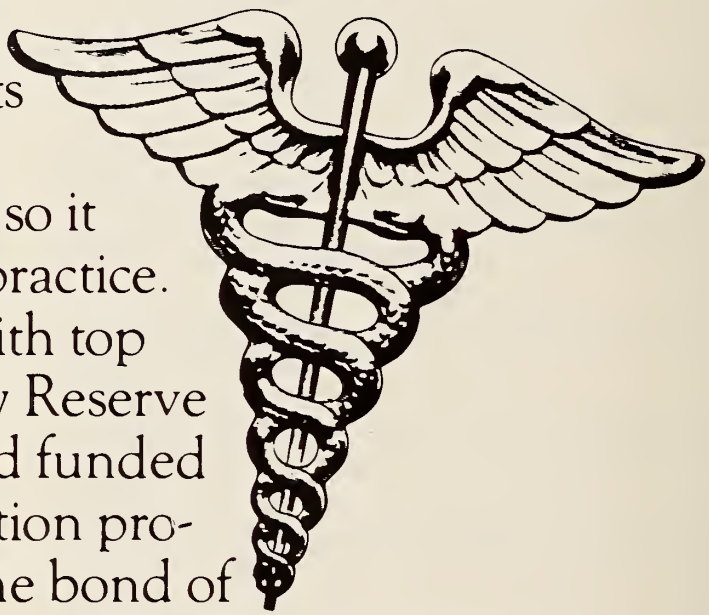
Dr. Harald H. Rossi of the Radiological Research Laboratory, Columbia University College of Physicians and Surgeons, gave advice during the preparation of the radiobiological section. Mr. Gene Jennings, R.T., assisted with the technical procedures. Dr. Jerry Allison and Mr. Ray G. Young, R.T., provided the dose calculations.

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A rare disease entity, this case report describes small bowel intussusception secondary to intestinal hypermotility of hyperthyroidism.

Hyperthyroidism with Associated Jejunojejunal Intussusception

JEFFREY R. LEE, M.D., *North Carolina,* JUDSON G. BLACK, M.D., and JOHN T. HORNEY, M.D., *Atlanta**

Abstract

Gastrointestinal hypermotility is observed in patients with hyperthyroidism. Hyperphagia, anorexia, nausea, steatorrhea, and increased frequency of stools have all been attributed to the metabolic alterations of hyperthyroidism. Presented below is a case report of multiple jejunojejunal intussusception and associated hyperthyroidism in a young woman.

Introduction

GASTROINTESTINAL MANIFESTATIONS of elevated circulating thyroid hormone are well documented, although the exact mechanism of action on the digestive tract is poorly understood. Patients with Graves' disease often demonstrate increased gastrointestinal motility, diarrhea, steatorrhea, hyperphagia, and decreased gastric secretions. Presented below is a case of hyperthyroidism and intestinal hypermotility with an unusual complication of jejunojejunal intussusception.

Case Presentation

A 24-year-old white woman presented in August, 1980, with intermittent colicky abdominal pain. The pain was first noted 3 weeks prior to admission, lasting 12 hours and resolving spontaneously. Three days prior to admission, the pain recurred and was intermittent, severe, and associated with nausea, vomiting, anorexia, and non-bloody diarrhea.

Her medical history included a dilation and curettage and cervical conization for Class III pap smear. She had no other pertinent past hospitalizations or operations. She took no medications and related no abnormal metabolic symptoms.

Physical examination revealed temperature of 99.6°, pulse 72, blood pressure 136/78. The neck was supple with no goiter. There was no exophthalmos or lid lay present. The lungs and heart were normal. The abdomen had hyperactive bowel sounds; there was diffuse tenderness but no muscular guarding, and there were no masses palpated. Pelvic and rectal examinations were normal.

The white blood cell count was 10,500, with 58 segmented neutrophils, 35 lymphocytes, and 5 monocytes. Hemoglobin was 12.9 mg%. Electrolytes were normal. An upper gastrointestinal series revealed a jejunojejunal intussusception in the proximal small bowel. Findings from a barium enema were normal.

The patient was placed on nasogastric suction and intravenous fluids. Over the next few hours, she was unimproved, and was therefore taken to surgery where three segments of jejunojejunal intussusception were identified in the proximal jejunum. The small bowel was extremely hyperperistaltic. Interestingly, each intussusception represented proximal bowel engulfing distal bowel due to the hyperperistalsis. Each intussusception was manually reduced, and the abdomen was closed. The evening postoperatively, routine thyroid functions included in a chemistry profile were returned and found to be elevated: T_3 of 35, T_4 of 22, free thyroid index (FTI) 7.7 (normal T_3 25-

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32; normal T_4 5-13; normal FTI 1.15-4.29). Inderal was started immediately, and she had no symptoms of thyroid storm.

Repeat thyroid function tests revealed a T_3 of 36, T_4 of 15.8, and FTI of 5.68. Thyroid scan was consistent with Graves' disease with a 24-hour uptake of 76%. Thyroid antibodies were negative. She was maintained on Inderal 40 mg. per day and was placed on Propylthiouricil 150 mg. per day.

One month following surgery, she became nauseated and once again presented with unrelenting vomiting. She was hospitalized and became asymptomatic when placed on a double dosage of Inderal (80 mg. per day). An upper gastrointestinal series was normal.

In late November, 1980, a rash developed on her arms and legs and was felt to be secondary to Propylthiouricil. At that time, her T_3 was 21, and it was decided to maintain her on Inderal alone. In addition, several months of amenorrhea were reported by the patient, and further investigation revealed an intra-uterine pregnancy of 24 weeks.

Whatever the mechanism, the documented steatorrhea and the accompanying hypermotility respond completely to thyroidectomy, anti-thyroid drugs, or Inderal.

One week after stopping the Propylthiouricil, she was admitted to the hospital with impending thyroid storm. She had sudden onset of nausea, vomiting, temperature of 103°, pulse to 130, pedal edema, and generalized lethargy. At this time, her T_3 was 28.1, T_4 was 20, and FTI was 5.63. She was placed on Inderal and SSKI. Her thyroid symptoms abated. Biopsy of the skin lesions revealed vascular proliferation and dilation consistent with spider angiomata of pregnancy. Propylthiouricil was restarted, and in April she delivered a healthy male infant. She now remains asymptomatic on Inderal and Propylthiouricil.

Discussion

Gastrointestinal dysfunction frequently occurs in patients with hyperthyroidism. Weight loss, hyperphagia, increased frequency of defecation, and periodic abdominal pain have all been attributed to elevated circulating thyroid hormone.

Gastrointestinal hypermotility has been well documented in patients with hyperthyroidism. Shirer[1] examined 42 hyperthyroid patients radiographically and found a significant decrease in barium transit times over normal controls. Christensen et al.[2] demonstrated bursts of peristaltic electrical activity in patients with hyperthyroidism, and this varied significantly from the slow sinusodal waves seen in normal controls. Chlebowski et al.[3] utilized intraluminal pressure studies and demonstrated that there was increased sigmoid colon motor activity in patients with hyperthyroidism, especially in patients with recurrent diarrhea.

Most patients who become hyperthyroid note an increase in the frequency of stools from one or less per day to two or more per day. Steatorrhea has been well documented in hyperthyroidism and may contribute to the observed increased frequency of stools. Thomas et al.[4] provided evidence to support hypermotility as the source of fat malabsorption and steatorrhea. Wiley et al.,[5] however, reported a 50% decrease in pancreatic enzyme secretion in patients with hyperthyroidism and felt that this decrease contributed significantly to steatorrhea. Whatever the mechanism, the documented steatorrhea and the accompanying hypermotility respond completely to thyroidectomy, anti-thyroid drugs, or Inderal.[4]

Gastric acid secretion may be diminished or absent in hyperthyroid patients. Initial reports related a 35% incidence of achlorhydria,[6] but by using an augmented histamine test, investigators have found a 2-15% incidence of achlorhydria in hyperthyroid patients.[7, 8]

An early explanation for the hyposecretion and achlorhydria observed in hyperthyroidism included overstimulation of the stomach by the sympathetic nervous system. Recent evidence, however, points to the association of hyposecretion and achlorhydria with gastritis in hyperthyroid patients. Williams et al.[9] demonstrated round cell infiltration and immunofluorescent antigastric antibodies in 37% of their patients with hyperthyroidism. Siurala et al.[10] found 30 of 59 patients with evidence of gastritis associated with gastric hyposecretion. The presence of antigastric antibodies does not correlate with the severity of the hyperthyroidism but does correlate with the degree of gastric hyposecretion.[9, 10]

Abnormal carbohydrate metabolism has also been described in hyperthyroid patients. With normal resting serum glucose levels, insulin levels have been reported as inappropriately high.[11] With oral glucose administration, the insulin and glucose peak together and return to normal baseline. This inappropriate elevation of insulin in the fasting state may imply insulin resistance but may also reflect elevated baseline carbohydrate output by the liver with compensatory hyperinsulinemia.[11]

Intussusception in the adult is an uncommon disease. Unlike intussusception in childhood, approximately 75% of adults demonstrate a discrete pathologic process as the lead point in the intussusception. A high incidence of tumors warrants early surgical

intervention in adults with proven intussusception.[12, 13] Colo-colonic intussusception is associated with high incidence of colonic malignancy and rather than being manually reduced, these lesions should be primarily resected.[13] An exception to this would be pre-operative colonoscopic diagnosis of a pedunculated polyp as the lead point. In this case, manual reduction of the colo-colonic intussusception with polypectomy or limited colon resection would be appropriate. Ileocolonic intussusception should be treated with primary excision unless a primary cecal tumor can be excluded.

Treatment of jejunojejunal, jejunoileal, or ileoileal intussusception, however, is not so straightforward. Approximately one-third of the small bowel intussusceptions are secondary to malignant tumors. Primary malignancy of the small bowel is rare, but if suspected, the intussusception should be resected without reduction. The majority of the malignant tumors involved in small bowel intussusception, however, are metastatic lesions, frequently from the breast or melanomas.[13] Reduction with limited resection is warranted in patients with metastatic tumors to the small bowel. Intussusception secondary to benign tumors as seen in the Peutz-Jegher syndrome may be reduced with a more limited bowel resection. In general, treatment for small bowel intussusceptions should be individualized, with a conservative approach toward extensive bowel resection.

Summary

This case report describes small bowel intussusception secondary to the intestinal hypermotility of hyperthyroidism. This disease entity is very rare and has not been reported in the contemporary literature of the last decade. Clinical hyperthyroidism was not suspected pre-operatively, and surgical reduction was indicated when the intussusception did not reduce spontaneously. As illustrated by this case, it is very important to include hyperthyroidism in the differential diagnosis whenever a patient is being evaluated for intestinal hypermotility disorders.

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Atlanta Vascular Society Formed Recently

On May 3, 1982, the Atlanta Vascular Society was formed. The object of this Society is to aid and encourage continued high quality work in the field of peripheral vascular surgery in the greater metropolitan Atlanta area. Through the exchange of ideas and scientific meetings, this Society hopes to contribute to the improvement of diagnosis and treatment of patients with peripheral vascular disease.

Officers of this Society are: President, Dr. Garland Perdue, Vice-President, Dr. J. Harold Harrison, and Secretary-Treasurer, Dr. David Rosenthal. Charter members of the Society include the following physicians: J. Hagan Baskin, Wylie Black, Mark Constantino, James Estes, Daniel Jordan, Eric Kahn, Oliver King, John Kirkland, Pano Lamis, Thomas Nolan, Miguel Marcucci, Edgar Rhodes, Atef Salam, George Skardasis, Robert Smith, Paul Stanton, Jr., Joseph Vandewater, and Douglas Whitney.

The Society will meet on a quarterly basis. Membership is limited to surgeons who are in good standing in their state medical society and are certified by the American Board of Surgery. Application for membership is available upon request by a member of the Atlanta Vascular Society.

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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (*i.e.*, that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn. b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, *e.g.*, isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DOSAGE AND ADMINISTRATION

ORAL

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, *e.g.*, LEVARTERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

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TABLETS

No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as: 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E.D. Hypertension (Suppl. II) *3*:230 (Nov.-Dec.) 1981

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This is the second in a four-part series of articles on immunologic development and disease.

Phagocytic Defects

MARGARET F. GUILL, M.D., *Augusta**

THE PHAGOCYTIC SYSTEM includes the wandering cells (polymorphonuclear leukocytes, eosinophils, monocytes) and the fixed tissue histiocytes and macrophages of the reticuloendothelial system. There may be intrinsic deficiencies in the number of cells, movement to the site of stimulus, phagocytic ability, or bactericidal capacity. The ability to produce chemoattractants and opsonic factors may also be impaired. Failure of these functions may lead to recurrent or smouldering bacterial or fungal infections.

The critical number of neutrophils necessary for the prevention of infection seems to be about 10% of normal — in the range of 500-1,000/cc.[1] Mild to moderate neutropenia (1,000-1,500/cc) does not seem to be associated with increased risk of infection unless accompanied by impairment in function.[2] Congenital disorders associated with neutropenia include aplastic anemia, cyclic neutropenia, congenital neutropenia, Schwachman's syndrome (exocrine pancreatic insufficiency with neutropenia and failure to thrive), enzyme deficiencies, and aminoacidopathies. Serial white blood counts are needed to differentiate cyclic neutropenia from congenital neutropenia or aplastic anemia. Aplastic anemia, of course, will be manifested by pancytopenia. Increased leukocyte count after a corticosteroid challenge would indicate sequestration in the bone marrow; increased count after epinephrine challenge would include peripheral margination and/or splenic sequestration of leukocytes. The presence of persistent neutropenia or neutropenia with abnormal leukocyte morphology would be an indication for a bone marrow study.

Many chemotactic factors interplay in promoting cell movement, but the complement components are the primary ones which can be measured easily. Intrinsic cellular defects in motion have been defined, possibly related to microtubular or actin dysfunction, as well as certain serum inhibitors of chemotaxis (though these are generally associated with secondary rather than primary immune deficiency states). Congenital disease processes associated with chemotactic defects include C5 dysfunction, deficiency of C1, C2, C3 or C5, and the Chediak-Higashi syndrome (recurrent infections, partial oculocutaneous albinism, giant cytoplasmic granules in leukocytes). The Hyper-IgE syndrome (dramatically elevated IgE, eczema, and recurrent infections) has been associated with defects in chemotaxis in some patients, but this may not be the primary mechanism for increased infection.[2, 3]

The most dramatic and best known of the phagocyte defects are those involving the impaired capacity to kill organisms once engulfed.

A Rebuck skin window, easily performed on an outpatient basis, can give a rough estimate of the ability of both polymorphonuclear and monocytic cells to respond to a chemoattractant: After controlled superficial abrasion of the skin, a chemoattractant is applied. A coverslip is applied to the area and changed at 4-hour intervals for 24 hours. The progressive pattern of cellular morphology on the serial coverslips indicates the response. Normally, polymorphonuclear cells dominate over the first few hours, with a mixed pattern of polymorphs and monocytes in the middle hours and monocytes predominating in the waning hours. Quantitative assays

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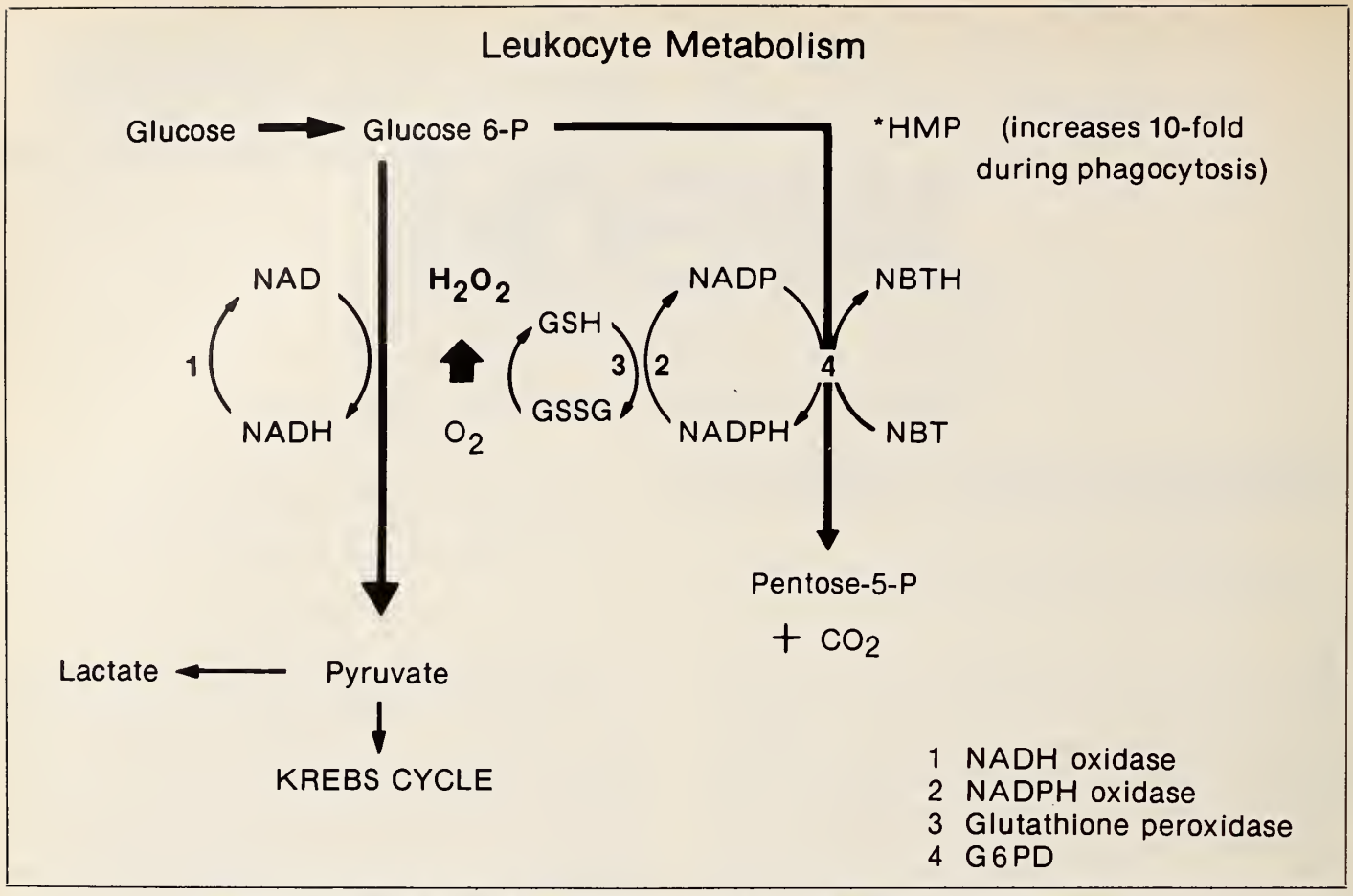


Figure 1 — Site of action of important enzymes in intracellular oxygen metabolism.

of chemotaxis or random cell mobility *in vitro* involve isolation of granulocytes or monocytes and exposure to one of a variety of chemotactic factors or to no specific attractant. Quantitation is accomplished either by counting the number of cells which migrate through a millipore filter or by measuring the progress of cells under agarose.

Disorders of phagocytosis involve failure of opsonization (antibodies, complement) as well as the intrinsic cellular defect seen in the Chediak-Higashi and "Lazy Leukocyte" syndromes. In at least one of our patients with a poorly defined immunodeficiency characterized by recurrent cutaneous infections, a serum inhibitor of phagocytosis and bactericidal activity has been identified but not defined.[4] There is no readily available office procedure for evaluating phagocytosis, but quantitative phagocytic indices can be determined by mixing known numbers of leukocytes and organisms *in vitro* and enumerating the colony-forming units remaining after specified time intervals. This is compared with cells from a normal patient evaluated simultaneously.

The most dramatic and best known of the phagocyte defects are those involving the impaired capacity to kill organisms once engulfed. Chronic granulomatous disease (NADH oxidase and/or NADPH oxidase deficiency), severe glucose-6-phosphate dehydrogenase (G6PD) deficiency, and glutathione peroxidase deficiency are characterized by failure of intracellular oxygen metabolism (Figure 1). Because of their inability to produce hydrogen peroxide, these patients are subject to smouldering infections with peroxide-negative, catalase-positive organisms such as staphylococcus, *Serratia marcescens, Escherichia coli, Klebsiella,* and *Aspergillus.* Myeloperoxidase deficiency is associated with delayed intracellular killing of the same spectrum of organisms due to the inability to utilize hydrogen peroxide. The nitrobluetetrazolium (NBT) dye test is a good screen for intact intracellular oxidation (Figure 2). Assays for G6PD, glutathione peroxidase, and myeloperoxidase are also available. Definitive diagnosis is by quantitation of intracellular killing and oxygen production. These are performed, as is the phagocytic index, with known numbers of cells and organisms monitored over a period of time. The evaluation of phagocyte disorders is reviewed in Table 1.

To date, there is no specific cure for any of these disorders except for bone marrow transplantation in cases of primary marrow failure. There have been *in vitro* and *in vivo* studies of the treatment of disorders with levamisole[5] or ascorbic acid,[6, 7] but the benefit has been inconsistent and difficult to duplicate.[8] Prompt recognition and aggressive treatment of infections with antibiotics have been the mainstay of therapy for these disorders. Some patients with chronic granulomatous disease have had long-term

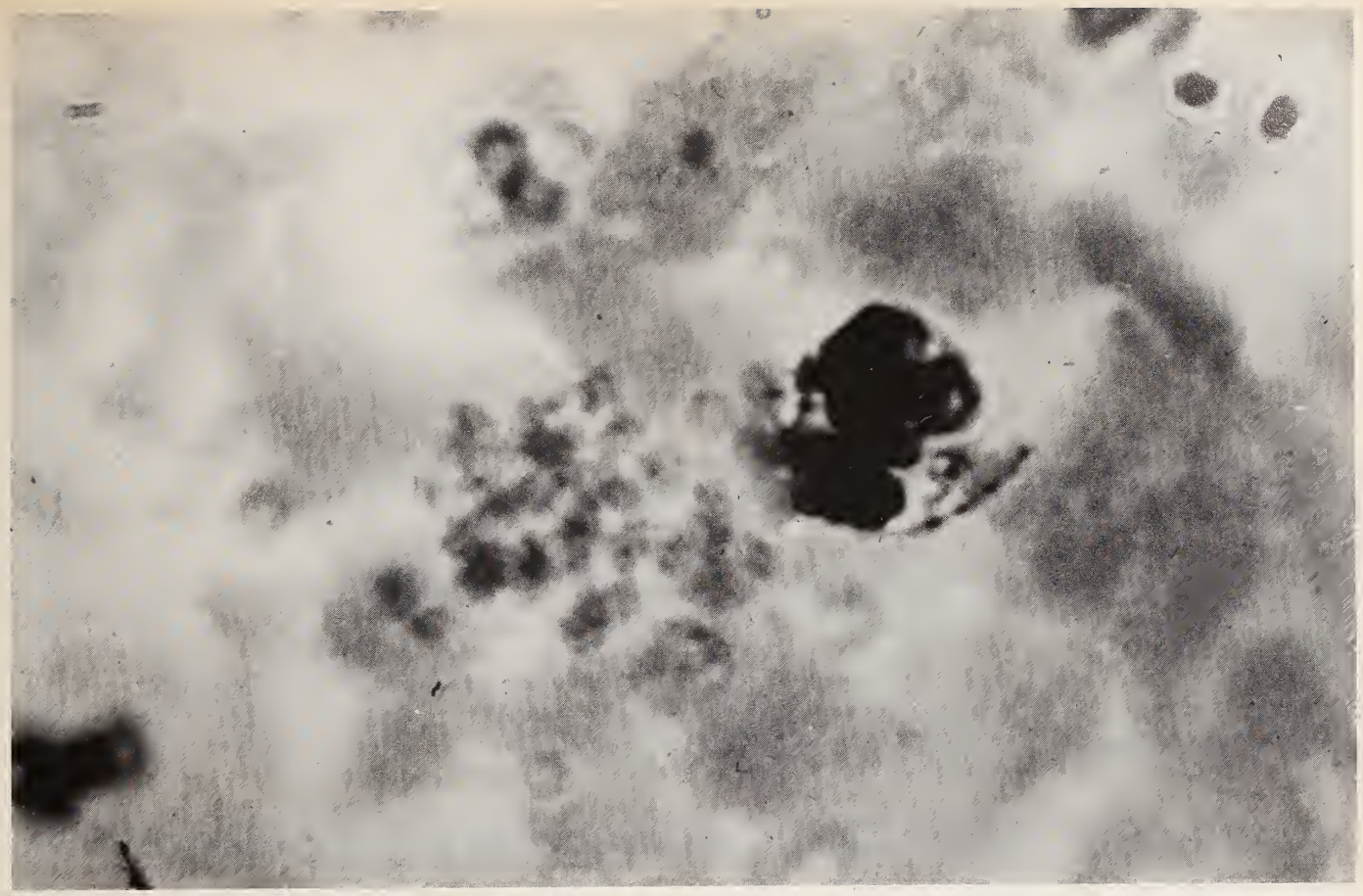


Figure 2 — NBT test: Colorless formazan dye is mixed with leukocytes and incubated for 30 minutes during which phagocytosis occurs. Presence of dark granules on smeared preparation of these cells indicates ability to reduce the formazan to nitroblue tetrazolium and, presumptively, intact intracellular oxidative metabolism.

sulfa therapy with apparent decrease in the incidence of infections.[9] Deficiencies of complement components and immunoglobulins can be corrected with periodic fresh frozen plasma infusions.

Secondary deficiencies in phagocyte function are associated with thermal injuries, overwhelming infection, malnutrition, diabetes mellitus, Down's syndrome, autoimmune disorders, rubeola, chronic renal failure and dialysis, and malignancy.[10] Treatment of these deficiencies hinges on treatment of the underlying disorder.

TABLE 1 — Evaluation of Phagocytic Disorders

Phagocyte Function	*Procedure for Evaluation*	*Disorder Associated*
Numbers	Serial WBC and differential	Congenital neutropenia
	Corticosteroid challenge	Cyclic neutropenia
	Epinephrine challenge	Schwachman syndrome
	Bone marrow	Aminoacidopathies
Movement	Complement screen	C5 dysfunction
		C1,C2,C3, or C5 deficiency
	Skin window	Chediak-Higashi
	Random mobility	"Lazy leukocyte"
	Directed chemotaxis	(?) Hyper IgE
Engulfment	Complement screen	Chediak-Higashi
	Quantitative immunoglobulins	"Lazy Leukocyte"
		Complement deficiency
	Quantitative phagocytosis assay	Hypogammaglobulinemia
Killing	NBT	Chronic granulomatous disease
	G6PD	
	Glutathione peroxidase	Severe G6PD deficiency
	Myleperoxidase	Myeloperoxidase deficiency
	Quantitative killing assay	Glutathione peroxidase deficiency

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Prolonged high quality survival can be achieved in this disease state with aggressive combined modality treatment.

Long-Term Survival in Small Cell Carcinoma of the Lung with Associated Symptomatic Intracranial Metastases

TROY H. GUTHRIE, JR., M.D., and PALAMALAI MAHIZHNAN, M.D., *Augusta**

Abstract

Three cases of small cell carcinoma of the lung presenting with symptomatic intracranial metastases are described in which prolonged high quality survival was achieved with aggressive combined modality treatment.

TRADITIONALLY, physicians, upon diagnosing intracranial metastases from solid tumors in their patients, regarded them as therapeutically hopeless cases, with the patients rapidly succumbing to neurologic death. This viewpoint has often resulted in a nonaggressive approach to the patient's management in which neither palliation of symptoms nor significant prolongation of life is achieved. Unfortunately, this nihilistic viewpoint has some valid background, since a series of patients with intracranial metastases treated with surgery and/or radiation have median survivals of only 3-6 months.[1] In addition, the quality of life for these patients is often poor.

Small cell carcinoma of the lung (SCCL) is an aggressive solid tumor with a remarkably high incidence of central nervous system (CNS) metastases.[2, 3] Approximately 10% of patients diagnosed with small cell carcinoma of the lung present with intracranial involvement.[4] In addition, as the length of overall survival increases due to improved therapy, so does the incidence of intracranial metastases; and at the time of death, many studies report total incidences of approximately 80%.[5] This staggering incidence has lead authors to suggest prophylactic cranial irradiation (PCI) as a means of increasing survival.[6, 7] PCI in carefully controlled studies does lower the rate of intracranial involvement to 5-10%, but it does not increase overall survival.[8, 9] It now appears that intracranial relapse in SCCL is merely a herald of systemic relapse for which a significant extension of life is rarely obtained by second-line chemotherapy. Thus, even medical oncologists may become discouraged about the prognosis of cases with intracranial involvement by SCCL, leading to less than optimum care.

With this background, three cases of small cell carcinoma of the lung presenting with symptomatic intracranial metastases are detailed below in whom high quality prolonged survival was obtained with aggressive therapy. A discussion on the unique therapeutic aspects of an initial intracranial presentation of SCCL contrasted to: a) other solid tumors and presenting with intracranial metastases and b) late intracranial relapse of SCCL will follow.

Case 1

A 64-year-old white woman presented in October, 1979, with the onset of focal seizures. Her history was negative for prior seizures or possible

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eliciting causes. Admission chest films showed right upper lobe and left hilar masses. Further evaluation included a computerized tomography (CT) scan showing a solitary right occipital brain metastasis. Elevated liver function studies and a positive bone scan suggested metastases in these areas. Tissue obtained by a right median sternotomy was diagnostic of small cell carcinoma of the lung by both light and electron microscopy.

Upon diagnosis, simultaneous daily whole brain irradiation to a total of 3000 rads and systemic chemotherapy (cyclophosphamide, 1000 mg/m^2, doxorubicin, 40 mg/m^2, and vincristine, 1.4 mg/m^2) was started. Three courses of cyclophosphamide, doxorubicin, and vincristine were given at 3-week intervals. In late December, 1979, radiation therapy (3000 rads in 2 weeks) was given to both lung masses and the mediastinum followed by immediate resumption of chemotherapy consisting of alternating CCNU, 80 mg/m^2, Methotrexate, 40 mg/m^2, and vincristine, 1.4 mg/m^2, with Cis-platinum, 100 mg/m^2 at 3-week intervals.

By March, 1980, complete resolution of the lung masses had occurred. In April, 1980, neurologic evaluation, CT scan, lumbar puncture, and EEG were normal. In June, 1980, the patient resumed full-time employment. The last course of chemotherapy was given in September, 1980. In October, 1980, a further 2000 rads in two weeks was delivered to the areas of the former chest masses and mediastinum. Full employment continued until July, 1981, when relapse occurred with hepatic metastases. Despite attempts at salvage chemotherapy with VP-16-213, the patient died in November, 1981, 25 months after diagnosis. At death, there was no clinical evidence of intracranial involvement.

Case 2

A 55-year-old white man was hospitalized in June, 1980, for evaluation of left hilar and lingular masses noted on routine chest films. Admission physical examination revealed slurred speech and left foot drop but was otherwise non-contributory. Bronchoscopy was negative. Immediately prior to left thoracotomy for tissue diagnosis, a generalized seizure occurred. Emergency CT scan revealed multiple intracranial lesions. Decadron, anti-convulsants, and whole brain irradiation (3000 rads in 2 weeks) were given with no further seizures occurring. A left median sternotomy obtained tissue diagnostic of small cell carcinoma. Systemic chemotherapy consisting of CCNU, 80 mg/m^2, Methotrexate, 40 mg/m^2, and vincristine, 1.4 mg/m^2, every 4 weeks was begun. After two courses in August, 1980, because of poor response, chemotherapy was changed to Cytoxan, 1000 mg/m^2, vincristine 1.4 mg/m^2, and procarbazine, 50 mg/m^2, days 1-14, every 4 weeks. In March, 1980, chemotherapy was again changed, this time to Cytoxan, 1000 mg/m^2, Adriamycin, 40 mg/m^2, and vincristine, 1.4 mg/m^2, with irradiation (3000 rads in 2 weeks) to lung mass and mediastinum delivered simultaneously with chemotherapy. Overall quality of life was good until May, 1981, at which time advancing disease resulted in death in June, 1981, 12 months after diagnosis.

Case 3

A 52-year-old black man with a history of hypertensive cardiovascular disease, congestive heart failure, and heavy cigarette smoking was admitted to the hospital in February, 1981, with complaints of headaches, decreased mentation, and hemoptysis of 3 weeks duration. Admission physical examination revealed severe obtundation without localizing neurologic signs and was otherwise unremarkable. Chest film showed a large left upper lobe mass, and a bronchoscopy obtained tissue diagnostic of small cell carcinoma of the lung. CT scan revealed multiple metastases in both cortical areas.

Initial treatment consisted of Decadron and 3000 rads in 10 daily doses to the whole brain. Prompt symptomatic relief occurred, and he was subsequently placed on Cytoxan, 1000 mg, days 1 and 8, vincristine, 1.4 mg/m^2, days 1 and 8, prednisone, 40 mg/m^2, days 1-14, and procarbazine, 50 mg/m^2, days 1-14. Because of persistence of the lung mass in June, 1981, the chemotherapy was changed to a Cytoxan, 800 mg/m^2, Adriamycin, 40 mg/m^2, and Methotrexate, 40 mg/m^2, regimen alternating every 3 weeks with CCNU, 60 mg/m^2, Methotrexate, 40 mg/m^2, vincristine, 1.4 mg/m^2, and Cytoxan, 400 mg/m^2, with almost complete resolution of the chest mass by November, 1981. In September, 1981, a repeat CT scan of the brain revealed persistence of the brain metastases and 1400 rads were given to the whole brain. The patient's clinical course since the original therapy has been symptom free, and he has an active life. The last outpatient visit was in February, 1982.

Discussion

The usual bleak prognosis of cases involving intracranial metastases stems from three factors. First, the maximum radiation tolerance of normal brain tissue is approximately 5000 rads delivered in continuous daily fractions.[10] This falls below the sterilization dosage for many solid tumors, particularly if bulky disease is present. Thus, the radiotherapist is obligated to leave residual viable tumor in the CNS and depending on the malignancy's growth rate, CNS symptoms rapidly recur in many patients. Second, and perhaps more important, is the fact that

as a rule, intracranial metastases represent one manifestation of widespread systemic disease for which, in many solid tumors, no adequate therapy exists.

Small cell carcinoma of the lung is a radiosensitive tumor with doses less than 5000 rads adequate to sterilize non-bulky disease. This is borne out clinically by two facts: 1) prophylactic CNS irradiation effectively prevents micrometastatic disease from becoming symptomatic[8, 9] and, 2) irradiation of the symptomatic patient with minimal to moderate neurologic dysfunction gives excellent results with no obvious alteration in survival.[4] Thus, the first problem of CNS control is eliminated, if severe neurologic dysfunction is absent, with moderate doses of radiation therapy.

Surveys of long-term survivors with small cell carcinoma of the lung include small numbers of patients with known brain metastases.

The second problem of control of systemic disease when intracranial metastases become symptomatic depends on the phase of treatment the patient is receiving. If intracranial symptoms occur as a manifestation of systemic failure of first-line chemotherapy, then usually systemic disease cannot be controlled with second-line chemotherapy,[11] and the patient experiences a rapid demise. On the other hand, if the patient presents with intracranial metastases, then systemic disease has a high likelihood of significant control, with response rates greater than 50% with present aggressive regimens even in extensive, widespread disease.[12, 13]

Therefore, the patient with small cell carcinoma of the lung who presents with intracranial disease without major neurologic dysfunction can expect both systemic and CNS disease to be significantly palliated and should be viewed optimistically as deserving modern aggressive therapy. In fact, surveys of long-term survivors with SCCL include small numbers of patients with known brain metastases.[4, 14]

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The silicone cast allows athletes to legally and safely return early to their sports activities.

Silicone Cast Treatment for Athletic Injuries to the Upper Extremities

STEPHEN C. HUNTER, M.D., and T. A. BLACKBURN, R.P.T., A.T.C., *Columbus**

Introduction

ATHLETES OFTEN sustain injuries to the upper extremity that leave them minimally impaired for performance in sports. If they could be splinted in an apparatus that would protect them and their fellow competitors from further injury, they could still play sports while the injury heals.

Hard casts used in protection of upper extremity injuries are illegal in athletic competition. The other athletes could be injured by the blows from this "weapon." A soft splint that is protective but legal is the answer to this problem.[1, 2] This discussion describes the application and results of such a device.

Methods and Materials

Football players with injuries to the forearm and hand were included in this treatment program. Most were treated in a hard cast until healing of the injuries had begun. They then were treated with the silicone cast and returned to early participation in sports. Several patients had definitive surgery for their injuries before soft cast splinting. Others chose to delay noncritical surgery until after the sports season was over. They were protected from further injury by the silicone cast technique during this period of time.

Cast Fabrication

The following supplies are needed for the application of the silicone cast:

one pint of RTV-11 silicone (a GE product)
one tube of catalyst
one roll of kerlex
tongue blades
underwrap
one medium-sized plastic bag
one 2-inch ace bandage or 2-inch conform tape
screwdriver
4 x 4's
scissors

The silicone cast is applied in a step-by-step method described below:

1. Put the patient's hand and forearm in a functional position both for the protection of the injury and for use in the sport in which the player is participating. This splint can be devised to create a thumb-spica cast if indicated.

2. Apply foam underwrap to the skin in a single layer. The cast should be approximately the same length as a standard short arm cast.

3. Mix the catalyst into the can of silicone, RTV-11. Stir for 3-5 minutes to prepare the mixture for application.

4. Wrap kerlex over the foam underwrap on the arm, covering the same area that the cast will ultimately encase.

5. Apply the RTV-11 mixture onto the kerlex with a tongue blade. It is necessary to impregnate the kerlex with the silicone material thoroughly. For areas that need extra reinforcement, 4 x 4's are added and also impregnated with the silicone material. This step may be repeated 2-3 times, depending on the strength of the cast needed.

6. Now cover the cast with the plastic bag. Contour and rub it on by hand to insure impregnation of the kerlex with the silicone material.

7. Wrap the cast with a 2-inch ace bandage or 2-inch conform tape, making certain the cast sets in a

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Figure 1 — Silicone rubber compound is applied onto the gauze wrapped on the injured extremity. This step is repeated in layers to achieve the desired strength and thickness.



Figure 2 — The silicone rubber cast is then molded and contoured while wrapped in a plastic bag to facilitate handling. It is then wrapped snugly with an ace bandage or conform tape.

close-fitting manner to the patient's upper extremity. The cast will take 3-4 hours to cure. At this point, remove the ace bandage and plastic bag.

8. Split the cast down the ulnar side and remove it. After it is trimmed, it is now ready for use in athletic competition.

The silicone cast can be taped over the arm securely whenever the athlete practices or participates in sports activities. The cast should not be worn more than 2 or 3 hours at a time, because the silicone rubber does not allow access of air to the skin. Maceration will occur if this cast is worn for extended periods of time.

Study and Results

Seventeen football players with injuries to the forearm and hand were treated with silicone casts to allow them early return to athletic participation. All were males, ranging in age from 13 to 24 years. Average age was 16.8 years. All injuries were sustained in sports contact activities. There were no open wounds.

Five players sustained forearm fractures, four of the distal radius and one of both bones of the forearm. None required surgical treatment. All were treated initially with a hard cast. The silicone cast was used 2-4 weeks after injury to allow the players to return to their sports activities. All fractures healed properly with no subjective complaints or objective deficits.

Five players had fractures of the metacarpals. One each had fractures of the 1st, 2nd, and 3rd metacarpals, and two had fractures of both the 3rd and 4th metacarpals. All athletes were treated initially with a hard cast and then progressed to the silicone cast 1 to 6 weeks after their injury. None required surgery. All fractures healed with good results on objective and subjective evaluation.

Carponavicular bones were fractured in two patients. One was diagnosed 4 months after the injury. Both were treated in a rigid cast for 2 months before silicone casting. Both patients' injuries resulted in nonunion of the carponavicular bone and are pending surgical bone grafting procedures.

Ligamentous injuries of the hand occurred in five other patients. Three had rupture of the radial collateral ligaments of the thumb metacarpal phalangeal joint. One had strain of the ulnar collateral ligament of the thumb metacarpal phalangeal joint. One other had rupture of the radial collateral ligament of the proximal interphalangeal joint of the long finger. Two patients were treated conservatively with a casting program. One patient had surgery at the time of injury and was placed in a silicone cast and was returned to play 2 weeks later. Two other players used silicone casts to finish their athletics and had definitive ligament repairs after the football season ended. All players had good results with stable joints, both subjectively and objectively.

Discussion

Lesser injuries of the upper extremity that require rigid immobilization with hard splints prevent athletes from competing in contact sports. The use of the silicone cast has allowed the athlete to wear a protective splint that is accepted by sport officials. For the most part, all injuries healed with good results, and the patients were able to return early to their athletic endeavors.

All of the injuries required a period of rigid immobilization to allow for primary healing. Once pain and swelling had abated, the use of the silicone cast was feasible, and the athletes could return to contact sports.

Good results were noted in all cases except carponavicular fractures. With this particular fracture's predilection for nonunion, it is not unusual to see these results. The early stresses of soft cast treatment probably did not help their prognosis.



Figure 3 — After curing, the cast is trimmed and split down its ulnar side to allow easy removal and reapplication.



Figure 4 — The cast can then be retaped to the athlete in a secure manner to allow protection during participation in sports activities.

Most materials needed to apply the soft cast are readily available in the physician's office or the athletic training room. The RTV-11 silicone material and catalyst are made by the General Electric Company. It is available at most electrical supply houses and costs approximately $13.

Summary

Seventeen college and high school football players with orthopaedic injuries to the upper extremities had silicone casts applied as part of the treatment for their injuries. This device allowed the athletes to legally and safely return early to their sports activities.

Five of the athletes had fractures of the forearm, five had fractures of the metacarpals, and two had fractures of the carponavicular bone. Five other athletes had ruptures of the collateral ligaments of the thumbs and fingers. All of the players were able to successfully return to their athletic competition. The only complications noted were delayed union of the carponavicular fractures.

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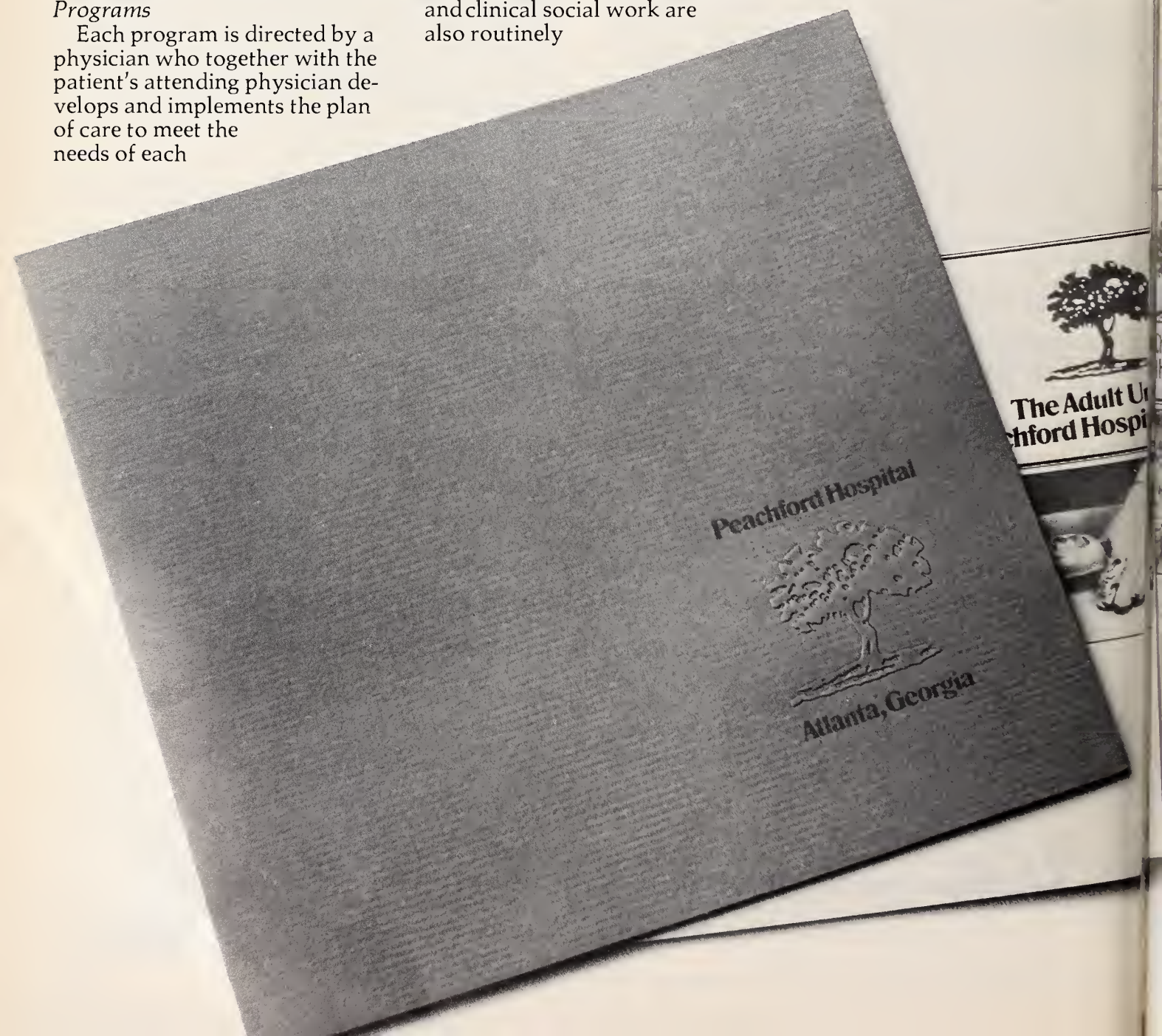
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rious problems.

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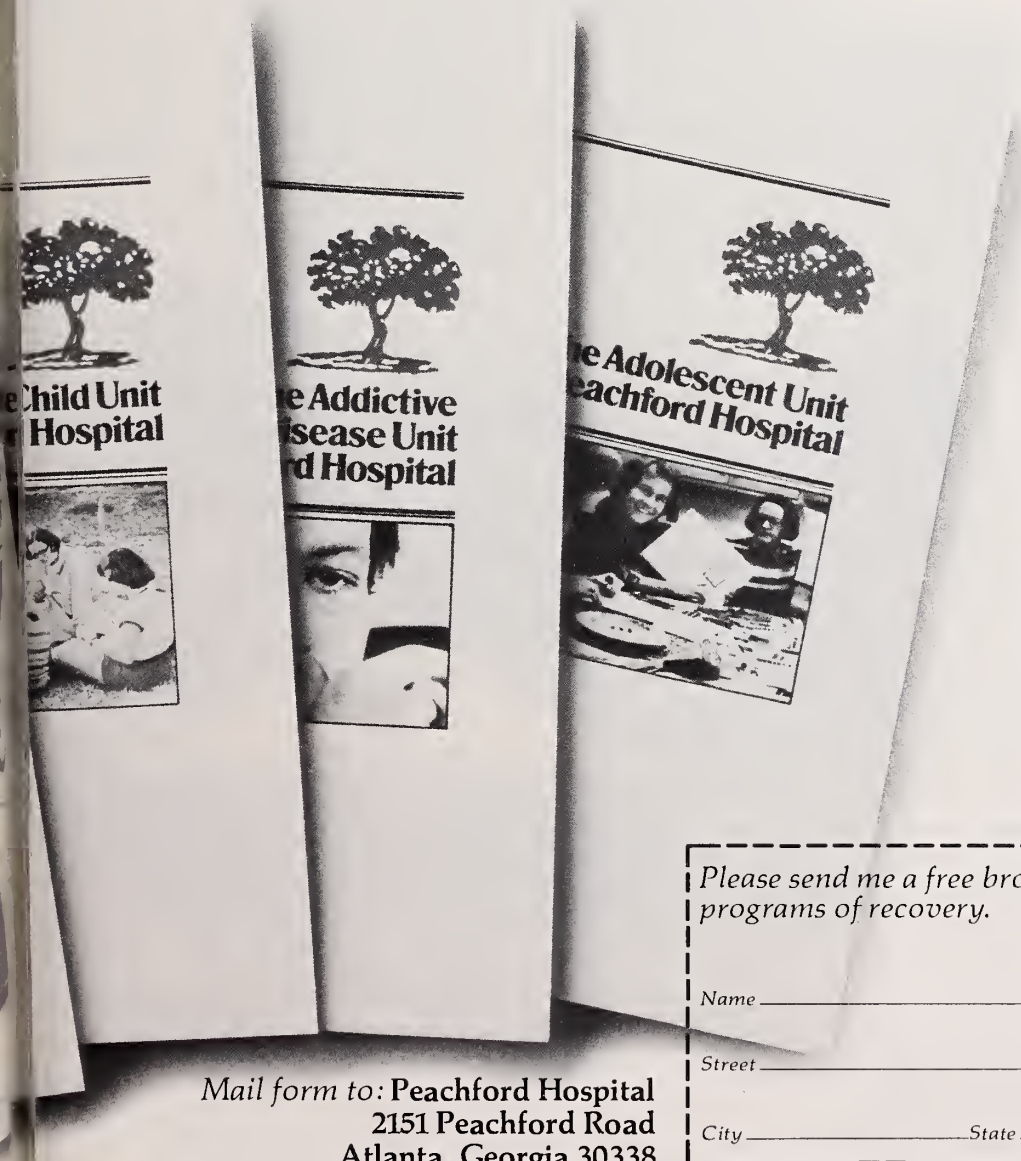
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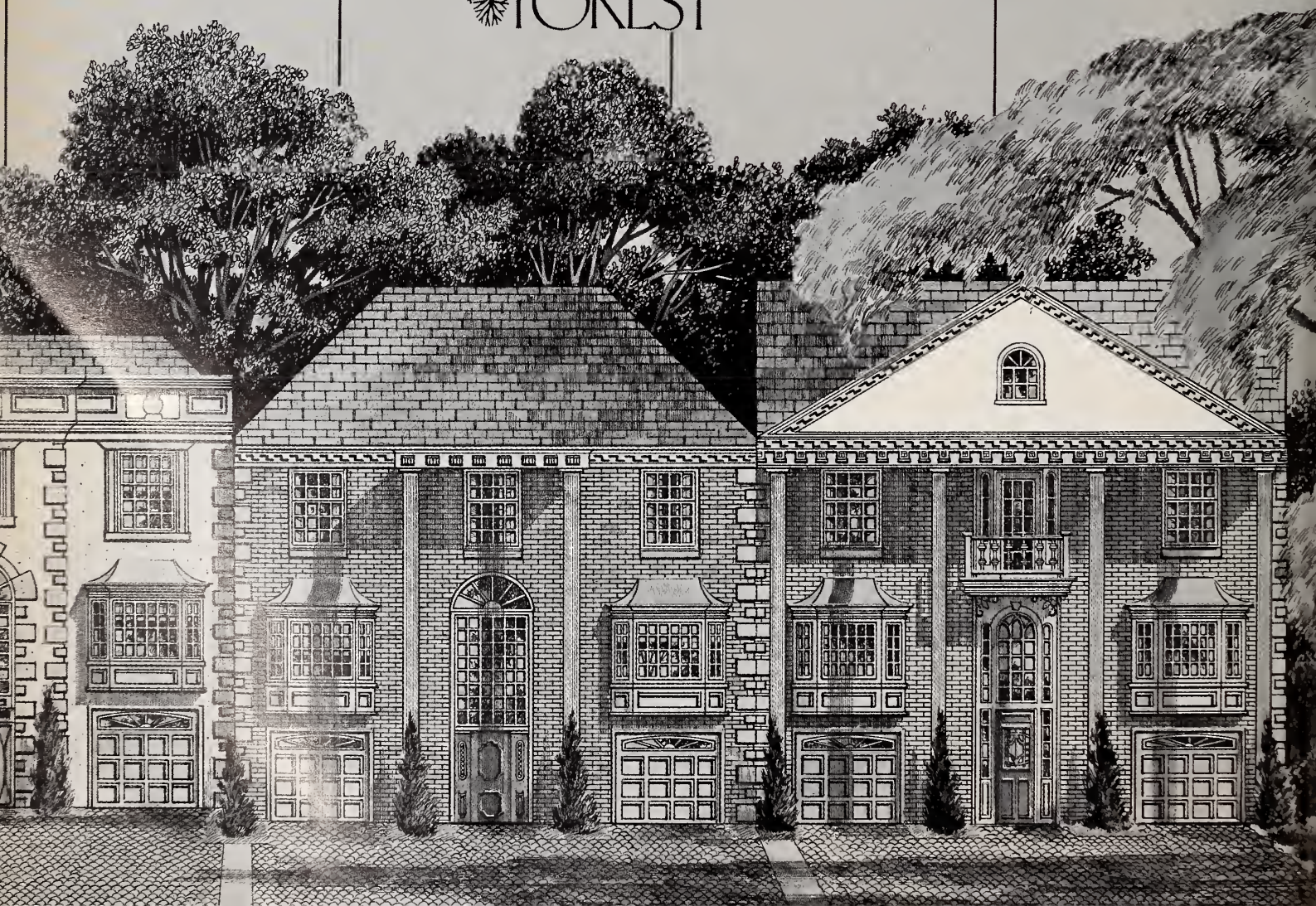
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With the current federal cutbacks, the public mental health system is reevaluating and redefining its goals.

Future Directions for Public Mental Health Systems

ILHAN M. ERMUTLU, M.D., *Atlanta**

In the past century, the public mental health system has gone through significant changes in philosophy and methodology approximately every 20 years. This may be a tribute to its vitality and youth. A system which does not encourage and promote change becomes stagnated. However, the absence of a clear scientific basis and validation of most of the prevailing theories in the field has prevented us from reaching lasting solutions to the problems with which the system deals. This absence has also resulted in a tendency to pursue fads and promising concepts with great enthusiasm. Many new techniques and methods introduced in the field resulted in disappointments after the initial enthusiasm settled down to routine work. Yet the search for better treatment approaches has continued.

Much has changed in our society since the passage of the Community Mental Health Centers Act in 1963.

A brief look at history vividly demonstrates the periodic steps taken, both forward and backward, by public mental health services. From the early humanitarian phase of institutional care initiated by Pinel in the 18th century, the system has vacillated between asylums of goodwill and warehouses of human misery, hospital-based services and office practice, child guidance clinics and comprehensive community mental health centers, and long-term hospitalization and deinstitutionalization. These changes apply not only to stage and scenery but also to the characters involved in the care of individuals afflicted with mental disorders. The concept of core mental health professionals keeps changing, depending on the time and place, from shamans, witch doctors, and priests to highly trained professionals and paraprofessionals.

Perhaps the most significant movement in the public mental health system occurred as a result of the 1963 Community Mental Health Centers Act. It was hailed by many as revolutionary. The ambitious beginnings of the era were seen as the brightest day for the system, with generous promises of fully coordinated human services, a readily available range of programs for the changing needs of the clients in the community, and an end to incarceration of citizens in outmoded institutions. What followed was unprecedented activity stimulated by federal dollars for the construction and staffing of mental health centers. In the meantime, the nation embarked on a program called deinstitutionalization to be aided by new psychotropic drugs and anticipated resources in the community. Thousands of severely disabled, chronically ill patients were placed in nursing and boarding homes. Others who were released ended up in dark alleys, jails, or in "ghettos" for the mentally disabled. The rapidly developed community resources could not keep up with the newly acquired clientele who not only needed effective mental health services but also required habilitation and extensive social services for food, shelter, and other basic necessities.

A by-product of this recent mental health "revolution" is that a large population of severely mentally disabled people accumulated in the community.

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Even though the majority of this group is quite manageable with proper aftercare and follow-up services, a relatively small number are unable to maintain themselves in an unstructured environment. This group consumes a large portion of staff time and effort with very little success. The problem of the severely mentally disabled person has become a political and economic issue, calling for a change in the goals and methodologies of the public mental health system.

Another factor that is influencing the change in the system is economics. The most powerful influence in the recent progress of mental health services has been the federal dollar. With the newly established trend in federal participation, or, to be more accurate, federal non-participation in health programs, the funding of community programs is at a crossroads. As the federal block grants decrease, there is no evidence of the state's willingness to fill the gap with state dollars. The pressure of certain advocacy groups has been effective in producing some state funds for various categories of programs, but such effort remains rather narrow in scope. The planned and balanced expansion of community programs is truly in jeopardy in the 1980s.

Rapid deinstitutionaliztion has created a major problem throughout the country by placing a relatively small but difficult population into the community.

The anticipated changes in the public mental health system will probably have significant impact on the staffing patterns of community programs. Application of approaches to community mental health programs with a primary orientation of social model has resulted in a mosaic of staffing patterns. The anticipated growth of programs and the lack of trained mental health professionals to meet the demand opened the door to many individuals of diverse training and background to assume critical responsibilities in the care of clients. The division of responsibilities may not have created unusual problems when the functions and territory of community programs were left unstructured and vague. However, present circumstances are demanding clearly defined roles and priorities for these programs. It is safe to assume that future staffing patterns will also reflect significant changes if the community programs are to produce expected results through their services.

If the public mental health system expects to meet the needs of American society in the latter part of this century, it must again change. This change must take into consideration the trends and potential developments in the field, fiscal policies, public sentiment, and the realities of the day.

Goals and Objectives Reexamined

It is essential that the public mental health system examines its goals and objectives. The ideology of community programs as dictated in the 1960s is no longer relevant or practical today. Then, the emphasis was on "comprehensiveness" and meeting the total needs of the community in the mental health field. There was no concern for limited resources. The goal was to establish an ideal community where all human services were perfectly coordinated. Everyone would receive the care he or she needed under optimum circumstances in the least restricted environment. Some of these objectives are still very valid and must be pursued. At the same time, however, it is necessary to maintain a realistic approach.

The Allocation of Resources

The tax dollars that support public mental health services are unlikely to increase at the same rate as in the past. For this reason, the extent of services will have to be reduced. The past philosophy which dictated that community programs be "all things to all people" must give way to a more modest but realistic one. We must now establish priorities in terms of target groups whose needs must come ahead of other clients in the community. Such priorities will also determine the kinds of services that should be emphasized. The allocation of resources in a given program will be made in view of these established priorities.

Effective Utilization of Trained Staff

To maximize the efficiency of services, it is necessary to establish a correct diagnosis of the case and develop a comprehensive treatment plan as quickly as possible. To accomplish this, the client must be seen by the most skillful clinicians as he/she enters the system. An intake system that leads the client gradually into highly trained staff is not only inefficient but also unfair to the client. The utilization of lesser trained staff for intakes has been a widely used approach in community programs. As the target population constitutes acutely and severely disabled persons, effective early intervention becomes a critical issue. The faster the treatment is instituted, the better the results are. Adequate medical and psychiatric coverage gains particular importance if a holistic approach is to be provided.

"Generic Services" — A Reorganization

Previous federal regulations promoted a categorical program approach to insure services for different age groups and problem categories. This resulted in circumscribed and distinct program entities in a community mental health center with their own hierarchy, causing the establishment of top-heavy

organizations. As resources diminish, it is obvious that the system cannot afford the luxury of placing too many highly trained professionals in administrative positions, thus reducing their clinical work. For this reason, a move toward "generic services" with personnel who are specialized in certain areas of the mental health field, functioning under a single program entity such as an outpatient clinic, offers a better alternative to setting up separate child, adolescent, adult, geriatric, and alcohol-drug services. Thus, a child can still be treated by a professional who is a specialist in childhood disorders even though the latter works in a multi-purpose outpatient clinic.

"Catchment" Areas Reexamined

The regulations of the Community Mental Health Centers Act required a defined "catchment" area with a population of 75,000 to 200,000. To meet this requirement, other administrative or geographic boundaries had to be disregarded. The result was a certain awkwardness in some areas. For example, one county was divided into three catchment areas with three independent centers, each having its own administrative structure. The repeal of the federal regulations now provides an opportunity to reexamine area lines, enabling the programs to consolidate on a more cost-effective basis.

Community Crisis Intervention Services

The reduction in state hospital beds has placed the institutions in a difficult position to handle the demand for services. Often the patient has to be discharged before he/she is fully stabilized. This merely increases the chances of readmission in a short time. Difficulty in finding a suitable placement in the community due to lack of sufficient residential alternatives is another problem facing the state hospitals. The result is that hospital beds are occupied by persons who do not need to be there. To reduce the dependence on state facilities, the community programs must establish effective crisis intervention services to be able to manage acute and severe mental disabilities locally. For the chronically disabled person, appropriate follow-up and maintenance services, adequate case management functions, along with service components such as day treatment and community residential facilities, are essential.

The Dilemma of Therapeutic Failures

Rapid deinstitutionalization has created a major problem throughout the country by placing a relatively small but very difficult population of severely and chronically disabled individuals in the community. Some of these patients are not able to maintain themselves in an unstructured environment regardless of how much support they receive from the local mental health and social agencies. They spend a good deal of their time in jails for petty crimes or get caught in the revolving doors of state hospitals. Today's system offers little in the way of long-term care. The fact is that this particular population of burned-out schizophrenics or deteriorated alcoholics do not need treatment in a hospital setting. Minimal professional services would suffice if they could be sheltered in a well-supervised, controlled, and humane environment. The time has come to admit the presence of therapeutic failures and deal with this group realistically rather than denying their plight.

Mental Illness Prevention

Another area that will receive increased attention in the future is prevention. The topic of prevention has been an elusive and hazy concept in the mental health field. Through the years, a great deal has been said about it with relatively little actual effort toward an organized program. One reason for the past inertia is the fact that implementation of primary prevention programs mostly depends on professionals and services which are not within the mental health system. Mental health professionals must be instigators rather than doers of primary prevention activities. When one considers the continuum of the mental health field, it is easy to appreciate the potential for prevention. Mental disorders that have an organic and/or physiologic basis are already receiving the benefits of scientific progress. Mental retardation can often be prevented. Recent findings in fetal alcohol syndrome and genetically determined metabolic disorders give sufficient clues as to the necessary action to prevent very serious mental disorders. Educational and anticipatory guidance techniques are shown to help individuals to cope with stress more effectively. The public mental health system has a special responsibility to stimulate activities which will have a significant impact on future generations.

In the 1960s, the emphasis was on "comprehensiveness" and meeting the total needs of the community in the mental health field. There was no concern for limited resources.

On another level, energetic secondary prevention measures are needed to prevent chronicity through effective early intervention during the acute phase of mental disorders. The importance of a good diagnostic work-up and effective therapeutic intervention which can only be provided by a system of quick response capability is obvious. For the mental health system, the emphasis on emergency and early intervention services is a must.

Contractual Arrangements Between the Public and Private Sector

The future should bring a fresh opportunity for partnership between public and private sectors. As the public programs narrow down their scope of activities, there must be a shift toward the private sector as a resource. It is hoped that the public system will have the capability to enter into contractual agreements with the private sector for the provision of services which are not available in the public sector. Such arrangements may prove to be more cost effective than actual program development. An acute need at present is the utilization of general hospital psychiatric beds to ease the increasing burden on state institutions.

Summary

The circumstances that are forcing a re-examination and re-evaluation of the organization, methods, and goals of the public mental health system undoubtedly will bring significant changes in many areas. Some of these changes are overdue and others are already occurring. The challenge is upon the system. How well it will respond will depend on the willingness of professionals to approach changes with a positive attitude. The new era will have its impact not only on service agencies but also on the institutions of higher learning where the professionals are trained. The new objectives and targeted client groups will call for somewhat different skills and approaches. For example, working with severely and chronically disabled persons has not been the choice activity for many highly trained professionals in the field. I believe there is ample cause for optimism about the future of the public mental health system. History clearly shows that it has come through other "revolutions" more mature and responsible. Mental health professionals must continue to have the talent and the will to achieve the systems' goals.

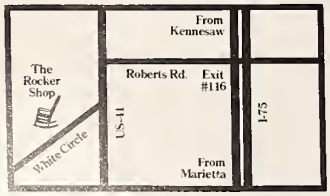
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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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THE MULTIVITAMIN/MINERAL FORMULATION

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Health Maintenance Organizations in Atlanta

There are currently five Health Maintenance Organizations (HMOs) in Atlanta, two closed-panel and three IPA types. Their advent has caused considerable interest, concern, discussion, thought, and speculation among physicians in the metro Atlanta area.

An HMO is a legally constituted organization selling comprehensive health care to voluntary enrollees for a finite number of dollars for a given year. It buys that health care for those enrollees through salaried physicians (staff model), a closed group of physicians (group model), or through an organization known as an independent practice association (IPA) where an individual physician practicing in his own office signs a contract to comply with the HMO's directives and needs. The first two types are called closed panel HMOs. HMOs have been given a marketing advantage in the dual option provision of the HMO law which guarantees them access to the employees of any employer who is paying unemployment compensation on 25 or more employees.

HMOs depersonalize medicine and undermine the physician's identity as well as his/her ideology.

Since there are a finite number of dollars available from the enrollees to finance a potentially infinite number of requests for services, it is obvious that a great deal of control is required by the HMO as to what their physicians can furnish.

Approximately 40% of all health costs are for in-patient hospitalization. HMOs on the average have cut the number of hospital days per thousand enrollees per year from approximately 850 to approximately 400.

To the physician, particularly a primary care physician or a psychiatrist, belonging to an HMO markedly restricts his freedom. He can only order significantly expensive overtures for patients after HMO authorization. He will realize that he was not selected by the patient out of all the physicians in the world but only those in the HMO — and then perhaps by chance. He will have to tell the patient what the HMO can and cannot afford in the way of medical care. He will have to compete with the other physicians in the HMO for the dollars available to the HMO and with physicians outside the HMO for patient satisfaction. He will not be motivated to protect his practice by providing the best service that he can through direct or telephone consultation with the patient but rather his practice size will be determined by the marketing arm of the HMO. It will depersonalize medicine and undermine his identity as well as his ideology.

For the patient, it will at first seem simple as he (or his employer for him) only has to ante up a certain amount of money once a year for which he is entitled to all the medical care he wants at any time. Practically speaking, whether he will like

what he gets after he has had to go to the nearest HMO facility to get it from someone whose survival does not depend heavily upon that immediate contact is open to question. He can, of course, only use those physicians on the HMO list for primary, secondary, and tertiary medicine.

From the standpoint of the employer, unless his hands are tied by a union, this also may be a simple and relatively economical way to render medical care. Since he gets to annually renegotiate the premium, he may be able to put pressure on the employees not to use the HMO unless absolutely necessary. Depending on the medical needs and/or wants of his employees, it might be acceptable to the majority of them or it may breed a great deal of employee dissatisfaction.

Since there are a finite number of dollars available from the enrollees to finance a potentially infinite number of requests for services, it is obvious that a great deal of control is required by the HMO as to what their physicians can furnish.

From the standpoint of the union, it would probably not be acceptable, at least initially. Union members are happiest if they can get any magnitude of medical care they want, anywhere they want it, from anyone they choose, at no financial outlay to them at all. With the HMO curtailing this in order to stay within its premium income, this might cause considerable union dissatisfaction.

As far as the government is concerned, to those members or agencies that really care what the cost of medical care is, it will probably diminish same. For those who simply use it as fuel for reelection, it might remove part of their grandiose platform.

As far as the American people as a whole go, it seems to me that this is a giant step backward. The entire matter of medical care is so complicated that it would be easy to defraud the average consumer of his self-sufficiency including his right to make a decision in an area where he would need considerable information and a fair amount of thought. It would tend to herd people like cattle into various chutes, and this does not help our national aspiration for self reliance.

All the above to the contrary notwithstanding, HMOs are in Atlanta, and Atlanta physicians will have to deal with them.

Louis H. Felder, M.D.
Atlanta

(Editor's Note: The Medical Association of Georgia does not have an official position regarding HMOs. As a forum for the expression of differing viewpoints, the Journal *welcomes other opinions on this subject. Address such letters to the editor.)*

"Insanity" — Plea or Ploy?

THE TRIAL OF A PRESIDENTIAL ASSAILANT has intensified public dissatisfaction with the legal concept "not guilty by reason of insanity." The clamor highlights salient features of the dilemma. Our system of jurisprudence requires that *intent* be considered a fundamental, inseparable component of any criminal act. At the same time, society demands protection. It is not yet possible to combine these two principles without doing serious injury to the legal system on the one hand or individual members of society on the other. For that reason, a legitimate plea often becomes a distasteful ploy.

The Georgia legislature recently enacted a statute which permits a verdict of guilty with the qualifying phrase mentally ill. The legislature and the Governor deserve commendation and support for this effort. Let us not for one moment entertain the belief that this complex question will be so neatly resolved. It is only

the latest in a long series of such efforts. Anticipating continued debate and difficulty, the citizens of Georgia would do well to adopt the succinct opinion expressed by Justice Weintraub as a practical guide by which our continuing efforts can be governed when the latest incident has faded from the forefront of public concern:

> "No one will dispute that society must be protected from the insane as well as the sane. The area of disagreement is whether a civil or a criminal process should be employed when forbidden acts have been committed. If we could think of a conviction simply as a finding that the mortal in question has demonstrated his capacity for anti-social conduct, most of the battle would be decided. What would remain is the employment of such post-conviction techniques as would redeem the offender if he can be redeemed and secure him if he cannot." *(Concurring opinion of Weintraub, C. J.,* in State vs. Lucus, *30 N.J. 37, 83, 152 A. 2 d 50, 75 (1959).)*

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A Summary of Legislative Responses to the Medical Malpractice Crisis

ROBERT N. BERG, *Atlanta**

MOST READERS are or should be familiar with what has become known as the "medical malpractice crisis": the substantial increase in the incidence and size of medical malpractice claims which emerged during the 1970s and has continued into the 1980s. It has been suggested by some that this crisis, if not curbed, poses a major threat to the effective delivery of medical care. The risks and consequences of medical injury must be stabilized in order to encourage the continued provision of medical care to the public at reasonable costs, the continued existence of medical care institutions, and the continued readiness of individuals to enter the medical care field. Moreover, some medical and legal scholars perceive that the medical malpractice crisis has caused an increasing reluctance on the part of insurance companies to write medical malpractice insurance policies. A dramatic rise in malpractice insurance premiums, in turn, has forced some health care practitioners to limit or cease to render health care services.[1]

State legislatures have responded to the existence of the medical malpractice crisis and the inherent dangers to the health care delivery system created by that crisis through the enactment of legislation. In some states, legislation has been adopted specifically designed to limit the amount of damages recoverable by a plaintiff in a malpractice suit or to limit the amount of damages recoverable from a particular physician defendant. Other states have sought to resolve the medical malpractice crisis through the creation of dispute resolution mechanisms, such as through the use of binding arbitration groups or pre-trial screening panels. Finally, some states have adopted procedural safeguards to deter the institution of spurious malpractice claims. Among these are provisions reducing the applicable statute of limitations or requiring that the defendant physician be notified of a malpractice claim within a certain time period prior to the institution of that claim; alternatively, other statutes require that a malpractice plaintiff obtain an expert opinion as to the meritorious nature of the malpractice claim *prior to* instituting a lawsuit, or impose criteria which must be met by experts testifying on behalf of the plaintiff at trial.

This article summarizes some of the more common and interesting legislative responses to the medical malpractice crisis and also describes some of the significant judicial reactions to those statutes in cases in which the constitutionality of the statutes has been challenged.

Limitations on Damage Recovery and Exposure to Liability

The most obvious means to solve the problem of increased malpractice judgments is to impose an upper limit on the amount of those judgments. Many state

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

legislatures did just that, although the precise mechanism used differs from state to state. For example, some states, such as Nebraska, Illinois, and Indiana, enacted statutes imposing ceilings on the aggregate amount of damage recoverable in a malpractice action; these ceilings range anywhere from $150,000 to $750,000. Other states enacted statutes imposing limits on the amount of damages recoverable with respect to any one claim or any one occurrence. For example, an Idaho statute places a limitation on recoverable damages in malpractice actions against physicians of $150,000 per claim and $300,000 per occurrence; a North Dakota statute limits damages resulting from any one occurrence to $300,000.

Other states adopted more specific statutes designed to limit the recovery of specific types of damages. Thus, statutes were enacted in New Hampshire and California which limited the amount of damages for non-economic loss, such as damages for pain and suffering.

Generally, statutes attempting to limit the amount of damages recoverable in malpractice actions have not fared well in challenges to the constitutionality of those statutes. In most cases, statutes of this type have been struck down on the grounds that they violate the equal protection provisions of the United States and applicable state Constitutions. For example, the Supreme Court of New Hampshire[2] struck down that state's malpractice statute because the damage limitation provisions established several unconstitutional classifications: first, the statute conferred certain benefits on one class of defendants (health care providers) that were not afforded to other classes of defendants; at the same time, the statute distinguished between plaintiffs whose injuries were caused by medical malpractice and all other types of plaintiffs. Moreover, the statute distinguished between medical malpractice victims whose claims exceeded the damage limitation amount and those whose claims did not. The Court struck down the statute, holding that these classifications were unfair and unreasonable and therefore denied equal protection of the law to certain malpractice victims and others.

The array of legislative responses to the medical malpractice crisis range from direct limitations on the amount of malpractice judgments to indirect procedural provisions designed to reduce the number of spurious malpractice claims.

Similarly, the Supreme Court of North Dakota struck down that state's malpractice statute on the basis that the ends sought to be achieved by the North Dakota legislature were not reasonably related to the means used to achieve those ends. As viewed by the Court, the goal of eliminating non-meritorious claims was not furthered by a statute which limited the amount of damages recoverable by patients with meritorious claims; nor was the goal of encouraging physicians to enter into and remain in the practice of medicine furthered by the damage limitation.[3]

Statutes limiting the amount of damages recoverable in a malpractice action have also been successfully challenged on the grounds that these statutes unconstitutionally denied due process of law to malpractice victims, were unconstitutional "special privilege legislation," or were unconstitutional as a denial of the right of the citizens of a state to obtain compensation for injuries to person and property.[4]

Other states have taken a more indirect approach to limiting damage recoveries in malpractice cases. For example, a Florida statute which survived a constitutional challenge required that medical malpractice damage awards be reduced by the amount the victims receive from collateral sources such as insurance companies. Likewise, an Indiana statute was upheld which imposed a limit on the amount of attorneys' fees which may be paid to legal counsel for malpractice plaintiffs.

Finally, the New York legislature is considering a bill which would limit a physician's liability in a malpractice case to the first $100,000 of any award, with the balance of the award, if any, to be paid out of a state-administered fund.

Creation of Dispute Resolution Mechanisms

Rather than limiting the amount of malpractice damages, several states opted for the creation of arbitration boards or screening panels as a means of resolving malpractice disputes short of trial. Generally, the composition, functions, and procedural effect of these boards and panels has varied from state to state. The success of constitutional challenges to these statutes has also varied from state to state, with the more formalized and binding pre-trial systems usually receiving closer judicial scrutiny.

The most restrictive type of statute is one in which all malpractice claims must be submitted to an arbitration board whose decision, if the parties so agree, would be final and binding. This type of statute was adopted in Illinois but was subsequently struck down by the Illinois Supreme Court on the grounds that it constituted an unlawful delegation of a judicial function to the non-judicial physician and attorney members of the board.[5]

A more typical statute involves the creation of special pre-trial screening panels designed to provide the parties to a malpractice dispute with an impartial, non-binding assessment as to the validity of the plaintiff's claims. While the use of these panels is mandatory in most cases, the effect on the plaintiff's constitutional rights is less restrictive than that of binding arbitration boards. The findings of the screening panels are not binding, although they generally may be introduced into evidence at a subsequent trial; nonetheless, the findings of the screening panels are designed to and in many cases do encourage the settlement of claims.

The constitutionality of statutes creating pre-trial screening panels was upheld, among other states, in Louisiana, New York, Delaware, and Indiana. On the other hand, courts in Illinois, Florida, and Pennsylvania struck down similar laws as violating the right to trial by jury. Also, legislatures in North Dakota and Nevada recently repealed malpractice statutes which created pretrial screening panels.

Procedural and Other Limitations on Malpractice Claims

Other states undertook numerous different means designed to reduce or eliminate the adverse effects of the malpractice crisis. Examples of these types of statutes include:

Reduced Statutes of Limitations: Many states adopted statutes creating a distinction between the generally applicable statute of limitations and the statute of limitations in medical malpractice cases. Georgia is one such state. Pursuant to *Ga. Code Ann.* §§3-1101 through 3-1105, a malpractice action generally must be brought within 2 years after the date on which the negligent or wrongful act *occurred,* regardless of when it was discovered. An exception to this 2-year statute of limitations is provided in cases where a foreign object is left in a patient's body. On the other hand, the general statute of limitations in Georgia requires that an action be brought within 2 years of the date in which the right of action "accrues," which was interpreted by Georgia courts to mean within 2 years of the date in which the wrongful act is discovered (which may be well after the date on which the wrongful act occurred). A similar statute of limitations provision is contained in the Indiana malpractice statute and was upheld by the Indiana Supreme Court.

Prior Notification: Some states, such as Texas and Maine, passed statutes requiring that the physician be notified of a potential malpractice lawsuit at least 60 days prior to the bringing of such suit. The purpose of such provision is to provide the malpractice defendant with some sort of warning before the commencement of expensive litigation, thereby giving the physician an opportunity to evaluate the claim and consider the possibility of settlement before costly litigation is undertaken. While statutory provisions of this type have generally been upheld, the New Hampshire Supreme Court struck down a similar provision on the grounds that the notice requirement was unreasonable and denied the patient plaintiffs equal protection of the laws.

Use of Expert Opinions: Several states enacted or are considering the enactment of statutes designed to dissuade the commencement of spurious malpractice

claims. For example, a bill presently pending in New Jersey would require plaintiffs in malpractice cases to attach to the complaint an affidavit attested to by a practicing physician or surgeon to the effect that "there exists a reasonable probability that the care, skill, or knowledge exercised or exhibited in the medical treatment that is the subject of the complaint fell outside acceptable professional standards or treatment practices." In the event that the affidavit was not provided, the court would be required, on motion of the defendant physician, to grant a summary dismissal of the action.

Alternatively, a recently enacted North Dakota statute provides that a malpractice action "shall be dismissable upon motion, unless the claimant has obtained an admissable expert opinion to support the allegation of professional negligence within 3 months of the commencement of the action or at such later date as set by the court." Certain types of malpractice cases are excluded from this general provision, such as cases involving lack of informed consent, unintentional failure to remove a foreign substance from within the body of a patient, and performance of a medical procedure upon the wrong patient, organ, limb, or other part of the patient's body.

Posting of Bond: Finally, a proposed bill being considered in New York seeks to put some teeth into the New York provisions creating non-binding, pre-trial screening panels. If passed, the New York bill would require the plaintiff in a malpractice action to post a bond to cover the costs of defending the suit in court if: (1) the screening panel's decision is unanimously in favor of the defendant, yet the plaintiff still proceeds to trial; and (2) judgment is rendered in favor of the defendant physician at trial.

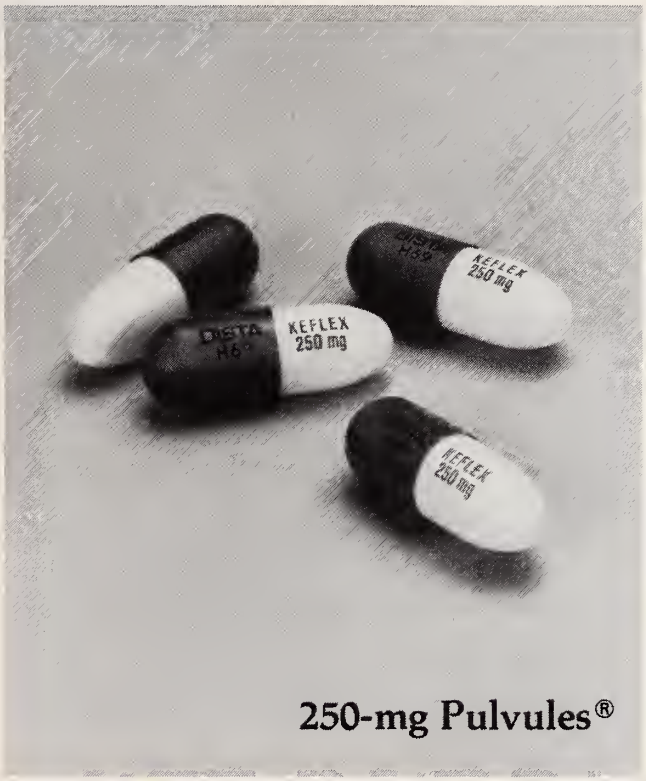
Summary

In total, the emergence and growth of the medical malpractice crisis has generated a wide array of legislative responses, ranging from direct limitations on the amount of malpractice judgments to indirect procedural provisions designed to reduce the number of spurious malpractice claims. Unfortunately, however, these legislative responses in turn have generated an equal number of challenges to the constitutionality of those statutes. Moreover, since courts in different states have disagreed as to the constitutionality of particular provisions, there is necessarily some confusion as to just how far a state may go in addressing the problems created by the medical malpractice crisis.

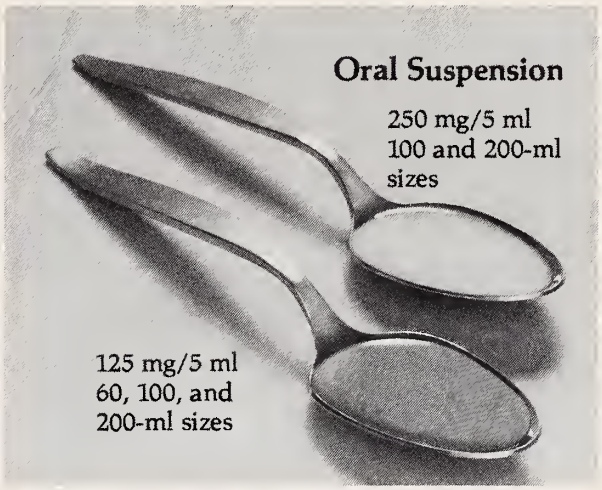
Notes

1. See, generally, "An Analysis of State Legislative Responses to the Medical Malpractice Crisis," Duke Law Journal, Vol. 1975, No. 6, pp. 1417-1468; Annotation, 80 A.L.R. 3d 583 (1977).
2. *Carson v. Maurer*, 424 A.2d 825 (S.Ct. N.H. 1980).
3. *Arneson v. Olson*, 270 N.W.2d 125 (S.Ct. N.D. 1978).
4. See, e.g., *Jones v. State Board of Medicine*, 555 P.2d 399 (S.Ct. Idaho 1976); *Wright v. Central DuPage Hospital Ass'n*, 347 N.E.2d 736 (S.Ct. Ill. 1976).
5. *Wright v. Central DuPage Hospital Ass'n, supra.*

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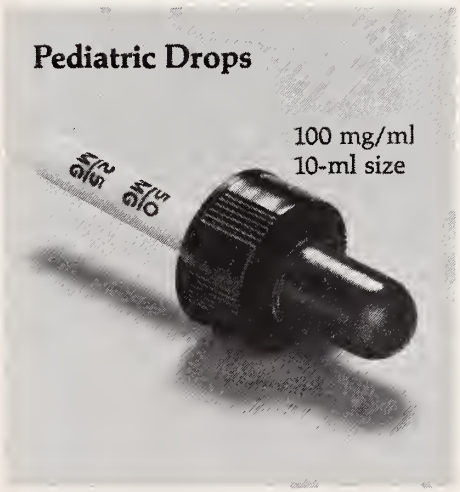
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president's letter



Education — The Key

The American people have the best health care system in the world, but they pay a high price for it — almost 10% of the gross national product. Some obvious reasons are:

1. Technology is more advanced. Diagnostic and treatment procedures are much more sophisticated than ever before and are thus more expensive;
2. People expect and demand more services, and their expectation of the benefits from these medical services has increased;
3. The constant threat of malpractice suits has placed pressure upon physicians to use more expensive tests and to hospitalize patients more often;
4. Perhaps as much as 30% of the cost can be allocated to nursing homes and to the care of the chronically disabled, which are actually social services and not medical services.

Physician fees constitute only about 14% of the total cost of medical services, so no significant benefit can be realized from a decrease in physician fees. It is also unrealistic to expect the cost of specific units of service to be reduced. Factors of inflation alone will prevent this. It seems clear, then, that the only way in which total cost can be affected favorably is to find ways to minimize the number of services offered. This probably can be accomplished if a cooperative project among physicians, businessmen, and the public can be developed. An effective educational effort directed toward all these groups will be necessary to convince each of the role it must play to produce results.

People must learn that ultimately each person is responsible for and in control of the state of his own health. With careful attention to lifestyle, people can be healthier and thus require fewer medical services. This is the only established method of "health maintenance." Somehow, people also need to feel that it is possible to care for many of their minor illnesses themselves, such as "flu," digestive upsets, and various minor aches and pains, without subjecting themselves to undue risk.

Businessmen can influence cost by negotiating different types of insurance contracts, particularly those that require deductible and co-payments from the patient and those that give incentives to physicians and patients for ambulatory care rather than hospital care. The business community can also help with the legislative effort to effect meaningful tort reform which would allow physicians to use judgment at times rather than tests and to treat patients on an outpatient rather than a hospital basis. Relief from the necessity to practice defensive medicine can make a substantial difference in the cost of care. Reforms eliminating duplicate payments for the same injury, requiring periodic payments rather than lump sum payments to the injured, and limiting the amount of awards for pain and suffering would all have substantial impact on cost. Physicians can probably work most effectively with businessmen through "business-medicine coalitions" to accomplish their common goals.

Finally, physicians can study and learn more precisely the cost effectiveness of various approaches to diagnosis and treatment. We do not have very much objective information about the true cost effectiveness of our practices at the present time. Physicians can also serve as educators for both the public and the business community, soliciting their help in a combined effort to work out the problems of cost escalation.

Education, then, will be MAG's first priority in developing meaningful projects for the year. It is reasonable to hope that educational efforts can be started this year and continued in subsequent years with the result that the state of health of the average person can be improved and the cost of medical services can be moderated.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.
President, MAG

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820 St. Sebastian Way, Ste 4-E, Augusta 30902

PERSONALS

First District

Claxton physician, **Curtis G. Hames, M.D.,** an international authority on cardiovascular disease and hypertension, was the guest lecturer at a dinner meeting of the Jenkins County Health Professionals Association. He outlined the "Stroke Belt" in the United States, noting that Jenkins County is in the center of this "belt."

Second District

H. Gordon Davis, Jr., M.D., was recently named Georgia Family Physician of the Year by the MAG in recognition of his 34 years of medical service. Feature articles about Dr. Davis appeared in the *Tifton Gazette* and *The Sylvester Local*. A reception was given in his honor by the Chamber of Commerce, Worth Community Hospital, and the Worth County Medical Society. Dr. Davis was also nominated for the National Family Physician of the Year Award to be presented by *Good Housekeeping* magazine in cooperation with the AAFP.

Third District

Lloyd B. Sampson, M.D., of Columbus, recently began the practice of dermatology on a special schedule in Americus.

Fifth District

David F. Apple, Jr., M.D., of Atlanta, was named to a 3-year term on the Board of Directors of the Metropolitan Atlanta Chapter of the American Red Cross.

Sandy Springs anesthesiologist, **John W. Patton, M.D.,** was appointed Medical Staff Chairman of Northside Hospital.

Sixth District

Jonesboro physician, **Wells Riley, M.D.,** was appointed to a second term on the State Board of Human Resources, which sets policy for the Georgia Department of Human Resources.

Eighth District

Isbin S. Giddens, M.D., of Lakeland, was honored recently at a reception. Dr. Giddens retired in January after almost 50 years of practice.

Ninth District

Erratum: In the "Personals" section of the May, 1982, *Journal,* **C. Neil Kelley, M.D.,** was cited for his recent election as President-elect of the Georgia Thoracic Society. Some of the accompanying information was incorrect: Dr. Kelley is from the Ninth District (not the Fifth), he is *not* associated with Emory but practices in Gainesville, and he *is* a member of the MAG. We apologize for this error.

Clarksville general practitioner, **Tom Lumsden, M.D.,** is the recipient of the Habersham County Chamber of Commerce's "Distinguished Service Award." He was praised as "a man who has not only unselfishly administered to the sick people in our area but also has served at times when necessary as their minister, praying with them and grieving with them."

Tenth District

Erratum: In the June, 1982, *Journal,* **Dr. Ramon Pineda Azahar,** of Milledgeville, was incorrectly listed as a non MAG member in the list of Physician's Recognition Award Recipients. Dr. Azahar has been an active member of the MAG since 1976. We apologize for this error.

Kenneth W. Horne, M.D., was recently appointed head of the radiology department at Minnie G. Boswell Memorial Hospital in Greensboro.

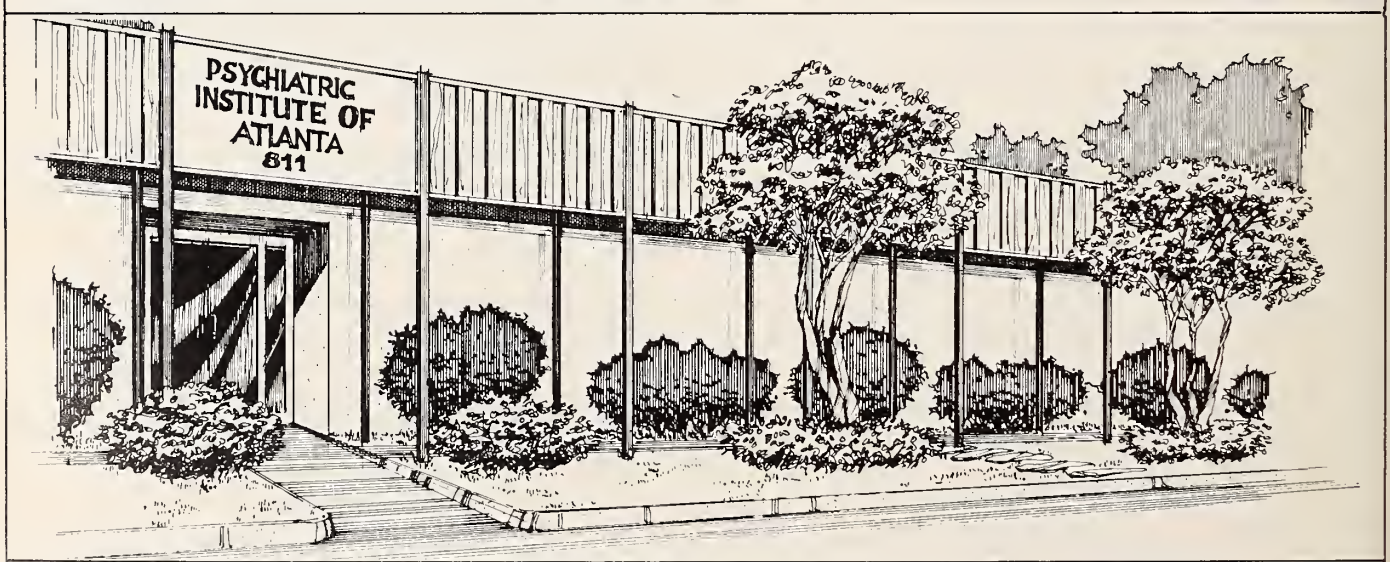
Sandersville physician, **William Rawlings, Jr., M.D.,** has been inducted as a Fellow of the American College of Physicians. Dr. Rawlings is a Diplomate of the American Board of Internal Medicine.

Three physicians were recently named to new posts at Eugene Talmadge Memorial Hospital in Augusta. **George Nelson, M.D.,** professor of obstetrics, was named associate chief of staff for utilization review and practice standards. **C. Robert Baisden, M.D.,** director of clinical pathological laboratories at Talmadge Hospital and associate professor of pathology, was named associate chief for institutional resources. **Donald C. Abele, M.D.,** professor in dermatology and medicine, was named associate chief for patients services.

Albert Carr, M.D., was cited in the *Augusta Chronicle* for his work in finding ways to combat hypertension.

Augusta physician, **Francis J. Tedesco, M.D.,** spent 2 weeks in China in March and April with the Executive Committee of the American Society for Gastrointestinal Endoscopy. The Society conducted a working tour at some of the hospitals and medical schools on the use of endoscopy.

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of the medical association of georgia
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MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

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CANCER PREVENTION STUDY II

An American Cancer Society Study of Environmental & Lifestyle Factors Related to Cancer

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THE COVER

The American Cancer Society is launching a massive investigation of the life-styles of Americans to identify risk factors associated with cancer. In Georgia, 30,000 persons will be interviewed by 3,000 volunteers. Dr. Underwood's article on p. 565 details interesting aspects of this Study.

Cover design by Richard Lyons of Richard Heiman Advertising, Atlanta.

Incidental Intelligence . . .

Delegates Attend Annual AMA Meeting — Dowda Elected



Representing Georgia doctors at the AMA annual meeting in Chicago (June 13-17) are, left to right: Col. Mims C. Aultman, M.D., (originally from Georgia but a delegate of the Assn. of Military Surgeons of the United States and now living in Miami, Fla.); Mr. Ken Williams, MAG staff; J. Dan Bateman, M.D., AMA delegate, Albany; John D. Watson, Jr., M.D., delegate, American College of Nuclear Medicine, Columbus; S. Wm. Clark, Jr., M.D., AMA delegate, Waycross; William W. Moore, Jr., M.D., AMA delegate, Atlanta; C. Emory Bohler, M.D., AMA delegate, Brooklet (Dr. Bohler is chairman of the AMA delegation from Georgia); Carson B. Burgstiner, M.D., AMA alternate delegate, Savannah; H. Hilt Hammett, Jr., M.D., AMA delegate, LaGrange; F. William Dowda, M.D., Atlanta (Dr. Dowda was elected to the AMA Board of Trustees and will no longer be a delegate); Joe C. Stubbs, M.D., AMA delegate, Valdosta; Harrison L. Rogers, Jr., M.D., AMA delegate (re-elected Speaker of the AMA House of Delegates), Atlanta; and Mr. J. Tom Sawyer, MAG staff.

Absent when this picture was taken and representing the MAG in attending the inauguration of the AMA Auxiliary officers are Charles D. Hollis, Jr., M.D., AMA alternate delegate (and President of the MAG), Albany; and Mr. Jim Moffett, Executive Director of the MAG.

In addition to Harrison Rogers' re-election as Speaker of the AMA House of Delegates and Bill Dowda's election to the AMA Board of Trustees, Mrs. John G. (Glenda) Bates, Cuthbert, was installed as President-elect of the AMA Auxiliary.

25th Anniversary of Crawford W. Long Museum

On Sunday, Sept. 12, 1982, the Crawford W. Long Museum will celebrate its 25th anniversary in Jefferson, Georgia. Physicians and their families and friends are invited to attend this Silver Anniversary celebration. Dr. Long first used ether anesthesia on March 30, 1842, to remove a cyst from a patient's neck.

The Museum was first opened in September, 1957, in a building built before 1860 on the foundation of Dr. Long's original office. The feature of the first floor of the Museum is a diorama of Dr. Long's now-famous first operation using ether. Also displayed are his diploma, a pardon and restoration to citizenship, as well as copies of documents establishing Dr. Long's priority in the use of anesthetic ether. The second floor of the Museum is devoted to a chronological story of the conquest of pain, or the development of anesthesia in history.

In September, 1979, the Museum was rededicated following a complete redesign and refurbishing made possible by contributions from the MAG and the Georgia Society of Anesthesiologists. Jefferson is 6 miles from I-85 (take U.S. 129/Jefferson exit) and 65 miles north of Atlanta. For further information, phone 404/367-5307.

Highlights of the AMA Auxiliary's Annual Meeting



Georgia's delegation to the AMA Auxiliary's annual convention included, left to right, front row: Mrs. William C. Tippins, DeKalb; Mrs. George Jones, DeKalb; Mrs. David C. Thibodeaux, Cobb; Mrs. Perry M. White, Medical Association of Atlanta; Mrs. Robley Smith, Tift; and back row, left to right: Mrs. Charles Hillis, Walker-Catoosa-Dade; Mrs. Robert Anderson, Cherokee-Pickens; Mrs. Brit B. Gay, Jr., Medical Association of Atlanta; Mrs. Charles M. Ward, Randolph-Stewart-Terrell; Mrs. Dent Purcell, Georgia Medical (Savannah), and Mrs. Talitha Russell, MAG staff.

Nine delegates and one alternate from the Auxiliary to the Medical Association of Georgia attended the AMA Auxiliary's annual meeting at the Drake Hotel in Chicago on June 13-16, to participate in the commemoration of the national group's 60th anniversary and to see one of their own members installed as president-elect. The delegation from Georgia was accompanied by Mrs. Talitha Russell of the MAG staff.

At the opening session of the AMA's House of Delegates at the Chicago Marriott on Sunday, June 13, the national auxiliary president, Mrs. Harry Dvorsky, of California, presented a check to the AMA-ERF for $1,742,913.68 to be distributed among the country's 126 medical schools, of which amount $27,471.43 went to Georgia's three medical schools.

The group also heard Mrs. Dvorsky's report on the White House Conference on Drug Abuse which she attended recently at the invitation of Mrs. Ronald Reagan to tell about the medical auxiliary's volunteer work in drug abuse, in which many of Georgia's county auxiliaries have taken an active part.

Mrs. Perry M. White (Katherine), immediate past president of the Auxiliary to MAG, gave a report before the Auxiliary's House of Delegates on the accomplishments of the Georgia organization during her term of office. She accepted membership awards for the five new county auxiliaries organized in the state. Georgia's delegates had the distinction of wearing the yellow button during the 4-day meeting, signifying an increase in membership over the past 3-year period.

The highlight of the annual meeting for the Georgia group was the installation on the final day of the sessions of Mrs. John G. Bates (Glenda), of Cuthbert, as president-elect of the AMA Auxiliary. This is the third time in the national group's history that a Georgian has been elected to this high office. Mrs. Allen H. Bunce, of Atlanta, served in this capacity in 1928-29, and Mrs. Eustace A. Allen, of Atlanta, held the post in 1947-48. Mrs. Bates will serve in 1983-84.

Another Georgian, Mrs. Milton B. Satcher, Jr. (Ann), of Atlanta, was named to the national group's Membership Committee to assist in recruiting new members in large metropolitan areas.

Other activities of the Georgia group included campaigning for Mrs. White as a member of the Nominating Committee, celebrating the winning candidacy of Dr. William Dowda, of Atlanta, to the AMA's Board of Trustees, and hearing their own new health education program for public schools, under the direction of Mrs. David C. Thibodeaux, president, and Mrs. Dent Purcell, health chairman, commended before the convention as a possible national project.

How to Have Effective Media Involvement

One of the medical profession's current challenges is learning to communicate effectively with media personnel. We can all be effective spokespeople if we approach the media with concern, enthusiasm, and professionalism. How can we achieve this? The following is a series of suggestions which I feel can be beneficial.

First of all, I think it is essential to establish an effective personal rapport with media representatives *before* a public relations crisis occurs. I receive many calls from physicians who become concerned about a sensational medical story, and the question is always the same: "How can I respond? Whom do I call?"

Recently, a medical story appeared on a local television station. The reporter who did the story was contacted by an area physician who demanded time to respond. The reporter answered, "I have no control over the response to my story. You must contact the news director." Frustrated and discouraged, the physician simply forgot about it.

To prevent this kind of frustration for yourself, I suggest that you or one of your colleagues send a letter to the station manager or program director of each radio and television station in your area. The letter would simply state your concern regarding health care information for the listeners and your willingness to be available if they should ever need additional information on a medical story. A similar letter could also be sent to the health editor of each local newspaper. Approached in this manner, most of these people will keep the letter and utilize your knowledge in the near future.

The next thing all of us can do is to understand media people from their point of view. People who work for the media are not just communicators selling air time for profit. They are professionals who take great pride in their expertise and in their commitment to provide accurate information. Many physicians have found the door slammed in their faces when they approached newspeople with a condescending, know-it-all attitude. If you approach them from the position of a mutual interest in accurate health care information for the public, the response will be much more positive. Respect their professionalism and expertise, and they will respect yours.

Over the years, I have had many of my colleagues as guests on my shows. I am always impressed by the vast knowledge of physicians. Occasionally, however, I find a physician who can explain in great detail the pathophysiology of coronary artery disease, but cannot tell an audience what a heart attack is. Remember to share your information with the audience or reader in a concise, easy-to-understand manner. My rule of thumb is to speak or write as if I were addressing a high school class. This is not to say that your audience is uneducated, but simply that most people comprehend what they hear or read at about an eighth- or tenth-grade level. I have long since stopped talking about coronary atherosclerosis. I now talk about hardening of the arteries of the heart.

Another point to remember is that the average attention span is no more than two or three minutes, so make your statements concise. A fifteen-minute response to "What is a heart attack?" will greatly enhance the ratings — of competitive stations. I used to think that two or three minutes was an extremely short period of time to communicate medical information. I now know that 90 seconds is a great deal of time in which a lot of good health care information can be disseminated in an understandable way.

I must make a point here about being interviewed for the printed media. Remember that when a reporter approaches you for information, he is not interested in a long dissertation regarding your personal feelings on the subject. He is interested in two or three crisp sentences that can follow the words, "A spokesperson for medicine said. . . ." If you expound at great length, you run two major risks. First of all, the reporter may simply get tired of listening and not quote you at all. Or even more importantly, he may quote you incorrectly or out of context.

For either print or electronic media, remember for whom you are speaking. Are you speaking for yourself personally? Are you speaking as a member of a professional organization? Or are you speaking for all physicians? The natural response is that you are speaking only for yourself, but beware! A reporter may quote you as speaking for a medical organization. Think before you speak.

So how can we do effective media PR? We must begin to establish rapport with representatives of radio and television stations and newspapers. We must learn who the editors or program directors are, and start now — before a crisis — by introducing ourselves. We must offer our help in any way that the station or newspaper might need us. When addressing public audiences, use concise, easily understood sentences. Be brief when called upon for comment, and remember for whom you are speaking.

Does this approach work? Yes, it does. Every reporter would love to have a respected authority to verify facts and to participate occasionally in the presentation of a story. You are already an authority on your subject; you can also be a polished spokesman for the medical profession.

Andrew P. Morley, Jr., M.D.
Chairman, Public
Relations Committee
DeKalb Medical Society

(Reprinted with permission from the DeKalb Medical Society Newsletter, June, 1982, issue number 5.)

Illegal to Prescribe or Dispense Methaqualone in Georgia

(The following information was published as a Letter to the Editor of the "Federation Bulletin," a publication of the Federation of State Medical Boards.)

This is to inform you of a recent action taken by the Georgia medical board which may be of some interest to readers of the "Federation Bulletin." The board sought legislation to place the drug methaqualone in Schedule I of the State Controlled Substances Act.

The board has been concerned about the operation of "Stress Clinics" in Georgia and particularly in the Atlan-

ta area. Board investigations yielded some staggering statistics concerning the magnitude of the problem; some of these statistics follow:

— Georgia exceeded all but seven states in the total grams of methaqualone prescribed in one year.
— More methaqualone was prescribed in one zip code area in Atlanta than was prescribed in thirty states; the metro Atlanta distribution of the drug exceeded the cumulative distribution in ten states.
— One pharmacy in Atlanta which serves clients of the stress clinics dispensed more than 182,000 methaqualone pills in one year; this exceeds the amount of this drug dispensed in each of fifteen states.

More methaqualone was prescribed in one zip code area in Atlanta than was prescribed in 30 states. . . .

— In the board's investigation of one stress clinic, the practitioners were conducting complete physical and psychological evaluations of patients before prescribing maintenance doses of methaqualone. In the course of the investigation, the office manager of this clinic told a physician who was seeking employment that he had nothing to fear from state and federal authorities for prescribing methaqualone on a regular basis, so long as he complied with the "concept" of the stress clinic (i.e., giving physical and psychological evaluations to all patients). An article in the March 15, 1982, issue of *Medical World News* explores this question of "legal loopholes" in more detail.

The board evaluated this problem in light of this information and found that the only effective way to deal with the problem was to seek legislation placing methaqualone in Schedule I of the Georgia Controlled Substances Act. With the help of the Georgia Secretary of State, David B. Poythress, the board was successful and legislation to this effect passed in the 1981 session of the Georgia General Assembly. This action makes it illegal to prescribe or dispense this drug in Georgia. Response from the public and medical profession has been quite favorable.

Andrew Watry, Executive Director
Georgia Composite State
Board of Medical Examiners
166 Pryor Street, S.W., 30303
April 14, 1982

Annual Convention of American Association of Medical Assistants Scheduled for September

The impact of legislative issues on allied health and the behavioral approach to patient communications are two of the many topics slated for the 26th Annual Convention of the American Association of Medical Assistants (AAMA) in Houston, September 20-24, 1982, at the Shamrock Hilton Hotel.

More than 20 educational sessions — geared to basic, intermediate, and advanced skill levels — will be held at the meeting. Special subject workshops will allow medical assisting practitioners, educators, and students to choose learning opportunities in their particular areas of interest.

General sessions on Monday, September 20, will feature a panel of experts on legislation and a session designed to identify medical assistants' and patients' behavioral tendencies, with instruction on how to use this self- and other-knowledge to facilitate patient relations.

Other topics to be addressed in workshops throughout the week include current ethical issues in medicine, management of stress, medical law, effective supervision of subordinates, and the advocacy of the profession through public speaking skills.

Among the faculty for the various sessions will be medical assisting practitioners and educators, physicians and other medical personnel from the University of Texas Medical Center and its sister medical institutions, and experts from related allied health disciplines.

Full details on registering for the meeting are available from AAMA's Executive Office: AAMA, One East Wacker Drive, Suite 2110, Chicago, Illinois 60601, 312/944-2722.

MEDICAL MEETING CALENDAR

SEPTEMBER

9-10—*Atlanta:* **Moral Issues in Medicine and Health Care.** Contact Bonnie Lawson, PhD, Health Program, Ctr. for Cont. Ed., Univ. of Ga., Athens 30602. PH:404/542-7553.

9-10—*Atlanta:* **Handicapping Conditions in Infancy.** Category 1 credit. Contact R. Dwain Blackston, MD, 440 Winn Way, Decatur 30030. PH: 404/294-3735.

10-12—*Savannah:* **Digestive Diseases: 12th Annual Meeting, Ga. Gastroenterologic Society.** Category 1 credit. Contact Jack Averett, MD, 2300 Manchester Expressway, Columbus 31904. PH:404/323-3671.

11-12—*Savannah:* **Georgia Society of Anesthesiologists—Cardiac Anesthesia in the General Surgical Patient.** Category 1 credit. Contact William Hammonds, MD, Secy.-Treas., Dept. Anesth., Emory Univ. Hosp., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/329-4603.

12-15—*Sea Island:* **Georgia Urological Assn. — Annual Meeting.** Contact Richard C. Estes, MD, Secy.-Treas., 35 Collier Rd., NW, Atlanta 30309. PH:404/255-0813.

15-17—*Savannah:* **Neonatology: The Sick Newborn.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

16-18—*Sea Island:* **Georgia Surgical Society — Annual Meeting.** Category 1 credit. Contact William C. McGarity, MD, Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, x3322.

17-19—*Atlanta:* **Medical Fair and Pre-Practice Seminar.** Contact Joe B. Lawley, PhD, State Med. Ed. Bd., Rm. 468, 244 Washington St., SW, Atlanta 30334. PH:404/656-2228.

24-25—*Unicoi:* **Georgia Rheumatism Society — Annual Meeting.** Category 1 credit. Contact Bill Stokes, Exec. Dir., Arthritis Found., 2799 Delk Rd., SE, Marietta 30067. PH:404/952-4354.

24-26—*New Orleans:* **Southern Medical Association Regional Postgraduate Meeting.** Category 1 credit. Contact Jeanette Stone, SMA, P.O. Box 2446, Birmingham, AL 35201. PH:205/323-4400.

26-30—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

27-29—*Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

30-Oct. 2—*Savannah:* **Southeastern Allergy Assn. — Annual Meeting.** Contact G. Frederick Hieber, MD, 1401 Monticello Blvd., North, St. Petersburg, FL 33703. PH:813/525-0861.

OCTOBER

4-5—*Atlanta:* **Contraception: Yesterday, Today, and Tomorrow.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

6-7—*Atlanta:* **Ga. Ch., American Academy of Pediatrics — Fall Meeting.** Category 1 credit. Contact William C. Mankin, Exec. Secy., 4059 Land O'Lakes Dr., NE, Atlanta 30342. PH: 404/237-3922.

7-9—*Hilton Head Island, SC:* **Fourth Annual Frontiers in Nutrition.** Category 1 credit. Contact Jane M. Greene, Ga. Inst. of Human Nutrition, BD 101, MCG, Augusta 30912. PH:404/828-4861.

14-15—*Atlanta:* **Use and Abuse of Antibiotics — Old and New.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Atlanta:* **The Basic Course on Pain: Diagnosis and Management of Chronic Pain.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-17—*Sea Island:* **Georgia Orthopaedic Society — Annual Meeting.** Category 1 credit. Contact James Averett, Jr., MD, 105 Collier Rd., NW, Ste. 2010, Atlanta 30309. PH:404/355-1798.

15-16—*Atlanta:* **ECG Interpretation & Arrhythmia Management.** Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

21-22—*Atlanta:* **Cardiology for the Emergency Department Physician.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-22—*Macon:* **Georgia Rural Health Conference.** Contact J. Stephen Wright, PhD, Ofc. of Rural Health, Ga. Southern Coll., Statesboro 30460. PH: 912/681-5144.

21-23—*Atlanta:* **33rd Annual Meeting — Association of American Physicians and Surgeons: Competition in Medicine — Good or Bad News?** Contact Daniel Jordan, MD, 35 Collier Rd., NW, Ste. 385, Atlanta 30309.

25-27—*Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

29-30—*Atlanta:* **Radiology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

30-Nov. 2—*Atlanta:* **SMA-MAG Scientific Assembly.** AMA, AAFP, ACEP and ACOG credits. Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in Ga.)

NOVEMBER

11-13—*Atlanta:* **Ga. Academy of Family Physicians — 34th Annual Meeting.** AMA Category 1 and AAFP prescribed credits. Contact Camille Day, 11 Corporate Sq., Ste. 205, Atlanta 30329. PH:404/321-7445.

12-14—*Callaway Gardens:* **MAG Leadership Conference.** Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 800/282-0224 (toll free in Ga.).

The Journal *is interested in receiving information on continuing education meetings in Georgia. Please mail such information* 2 months in advance *of the issue in which you wish it to appear to: Stephen Davis, Director of Education, MAG, 938 Peachtree St., NE, Atlanta 30309.*

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Kales A *et al: JAMA 241:*1692-1695, Apr 20, 1979. **4.** Kales A *et al: J Clin Pharmacol 17:*207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **6.** Kales A *et al: Clin Pharmacol Ther 19:*576-583, May 1976. **7.** Kales A, Scharf MB, Kales JD: *Science 201:*1039-1041, Sep 15, 1978. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27:*541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*(10):25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Zimmerman AM: *Curr Ther Res 13:*18-22, Jan 1971. **14.** Kales A, Kales JD: *Pharmacol Physicians 4*(9):1-6, Sep 1970. **15.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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*Please see following page for Brief Summary of Prescribing Information.



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CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (*i.e.*, that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, *e.g.*, isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY: The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DOSAGE AND ADMINISTRATION

ORAL

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg); IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, *e.g.*, LEVARTERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as: 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E. D.: Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981

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Cryptococcal Meningitis: A Case Report and Epidemiologic Study

PAUL D. WHITE, JR., M.D., *Albany,* LEO KAUFMAN, Ph.D., ROBERT J. WEEKS, *Atlanta,* MACK D. JONES, M.D., *Albany,* and JAMES A. HOTZ, M.D., *Leesburg**

Abstract

A case of cryptococcal meningitis resulting from exposure to pigeon fecal material in a grain-drying building is presented. Cultural and serologic procedures were used to establish the diagnosis, and the patient was successfully treated with flucytosine and Amphotericin B. The source of exposure was established by environmental studies.

Cryptococcosis is not considered a reportable disease by the Centers for Disease Control (CDC) in Atlanta, and thus only a small number of cases are documented each year. However, the disease is not as uncommon as it was once thought to be. For the 10 years between 1969-1978, an average of 126 deaths per year have been reported.[1] Sera from suspected cases of cryptococcosis have been received by the Division of Mycotic Diseases of the CDC since 1965; in that year, only 101 specimens were received. In 1976, a total of 9702 specimens were received and tested. During the 10 years, the number of confirmed cases increased from 24 to 338 annually.[2]

The case of cryptococcal meningitis presented here is somewhat unusual in that the probable source of exposure was established by environmental studies of the patient's work area.

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Case Report

The patient was a 47-year-old white male farm mechanic living in Calhoun County, Georgia. He was in excellent health until Nov. 14, 1980, when he had a severe morning headache. He related the headache to the firing of a muzzle loading rifle the previous day when he felt something hit his right eye. The patient had been blinded in his right eye from an injury sustained 25 years ago. He immediately consulted a local physician who referred him to an ophthalmologist whose evaluation did not reveal a foreign body or penetrating injury to the right eye or orbit. The patient's headaches persisted, and he was hospitalized by his local physician for a week for a possible "migraine headache." X-rays and other test findings were negative, and he was transferred to Tallahassee, Florida, for further neurologic evaluation of his headache.

At the Tallahassee Memorial Hospital, an electroencephalogram, computerized tomography brain scan, and routine laboratory studies were negative. Lumbar puncture (LP) was performed on Nov. 24, 1980, and showed protein 92 mg%, glucose 52 mg%, white blood cell count (WBC) 72/mm^3, with 72% lymphocytes. An India ink preparation revealed encapsulated yeast cells in the cerebrospinal fluid (CSF). The latex agglutination (LA) test for cryptococcal antigen was positive with a titer of 1:16. A repeat LP on Nov. 29, 1980, showed protein 76 mg%, glucose 44 mg%, WBC 122/mm^3 with 12% neutrophils and 88% lymphocytes. An India ink preparation was positive for encapsulated yeast cells. The LA test was positive for cryptococcal antigen with a titer of 1:32. Gram stains of the CSF were negative for bacteria. A culture of the spinal

fluid yielded *Cryptococcus neoformans*. Results of additional laboratory tests were as follows: total cerebrospinal fluid protein (CFP) 92 mg% (normal, 15-45), IgG 14.0 mg% (normal, 0-8), and ratio IgG/CFP 15.2% (borderline results 11-16). The results of other routine studies including a complete SMA-18 biochemical profile, a complete blood count, and urinalysis were normal. Rheumatoid arthritis and antinuclear antibody tests were negative. Prothrombin and partial thromboplastin time were normal. The glucose tolerance test results were within normal limits, and the urine glucose was negative.

On Dec. 2, 1980, the patient was transferred to a general hospital in Albany, Georgia, near his home, for management. Neurologic examination showed the patient to be alert, oriented, and cooperative without complaints, except for headaches with slight pain in the lower back when flexing the neck forward. His vital signs were within normal limits, weight 132¼ pounds, with his normal weight stated to be 150 pounds. General physical and neurologic examination results were normal except for his blind right eye. An opaque corneal scar was present as was a small, inferiorly deviated right pupil. The left pupil reacted directly. The remainder of the examination results were normal, except for a slight droop of the right upper lid.

He was begun on a 6 weeks' regimen consisting of Amphotericin B, 20 mg intravenously daily, and flucytosine, 9000 mg daily with divided doses every 6 hours. The blood urea nitrogen, creatinine, hematocrit (Hct), WBC, platelets, serum glutamic oxalic transaminase (SGOT), potassium, and urinalysis were monitored every 4 days and remained within normal limits. The patient became asymptomatic 1 week after therapy was begun. His clinical course was uneventful except for a papular rash of one day's duration and an abscessed tooth. Repeat LPs on Dec. 26, 1980, and Jan. 15, 1981, were negative by the Gram and India ink stains and for cryptococcal antigen. On the last LP, there were only two lymphocytes, and the protein and glucose determinations were within normal limits.

The patient was discharged on Jan. 16, 1981, to be followed by repeat LPs. Two were performed in March and July. Both were within normal limits. There was no growth on culture, and India ink and cryptococcal antigen tests were negative.

Epidemiologic Investigation

The clinicians managing the case requested the District Health Director to conduct an epidemiologic investigation in an attempt to determine the source of the infection. On April 17, 1981, the Health Director visited the patient at his place of employment. The patient denied any contact with fowl, other than his exposure to pigeons at his place of employment.



Figure 1 — Grain-drying building where the patient worked from which samples positive for *Cryptococcus neoformans* were taken.

While working, the patient visited three buildings that harbor feral pigeons. Pigeon droppings were collected from within each of the buildings. Inside each building, live pigeons were in evidence. The first sample was taken from the inside of a grain-drying building. Loaded grain carts were brought into the ground level of this building (Figure 1). The carts were then emptied, and the grain was transported to the upper story of the building to a large storage bin by a conveyor belt. The grain was then dumped into large trucks that entered at the ground level. The building was used primarily during the harvest season for peanuts in August and September and for soybeans in October. During this time, a tremendous amount of dust was generated around and inside of the building. The patient participated in these operations and repaired the machinery in the upper story where the pigeons and their droppings were located. He was the only person who worked on the machinery in the building.

Sample number two was a composite one collected from the loft area of two barns. Tractor parts were stored on the ground level in these structures. The patient visited these areas throughout the year to obtain parts but remained within the barns for only a brief period at each visit.

Eight persons who worked either in or around the buildings were employed on the farm. They were interviewed about their length of employment and exposure to the varied environment, and blood specimens were drawn.

The two samples of pigeon droppings and the eight blood specimens from the other workers were submitted for study to the Division of Mycotic Diseases, Center for Infectious Diseases, at the CDC.

Isolation of the Organism

At the CDC, the environmental samples were processed for the isolation of *C. neoformans* by a

direct and an indirect isolation technique.[3] Briefly, the direct method consisted of serially diluting a 1:5 W/V solution of excrement and spreading 0.1 ml of each dilution evenly onto plates of a medium. This medium was prepared by blending 50 gm of *Guizotia abyssinica* seeds in 100 ml distilled water, bringing it to 1000 ml volume, adding 5 gm oxbile, 50 mg chloramphenicol, 20 gm agar, and autoclaving at 15 PSI for 15 minutes. The inoculated plates were incubated at 24°C and observed daily after 72 hours incubation. All yeast-like colonies that appeared on these plates and which exhibited the brown color characteristic of *C. neoformans* were subcultured, purified, and identified by their biochemical patterns.

For the indirect isolation procedure, 1 ml of the 1:5 dilution of each suspension was inoculated intraperitoneally into each of four white Swiss mice. These were killed after 4 weeks, and their livers and spleens were inoculated on modified Sabouraud's dextrose agar containing 0.05 mg chloramphenicol per ml.

C. neoformans was isolated from the two samples of pigeon droppings by both the direct and indirect methods. The number of colony forming units (CFU) was determined for each sample by counting the number of *C. neoformans* colonies on the direct isolation plates and extrapolating back to the original sample. The number of CFUs per gram of sample was calculated to be 24.4×10^6 in the sample collected from the grain-drying building and 1.9×10^6 in the sample from the barns.

Discussion

The patient had appeared to be in excellent health until the onset of his symptoms and was not found to be immunosuppressed. He was placed on the treatment protocol described by Bennett et al.[4] consisting of a 6 weeks' course of combined flucytosine (150 mg/kg/day) and Amphotericin B (0.4-0.8 mg/kg/day). In contrast, the treatment schedule for Amphotericin B alone is 10 weeks. According to Bennett, the combined drug course cured or improved more patients and produced fewer failures or relapses, more rapid sterilization of the spinal fluid, and less nephrotoxicity than did Amphotericin B alone. Our patient tolerated the medication well, as evidenced by his uneventful clinical course except for a rash of one day's duration.

Another important advantage to using the shorter treatment schedule is the economic aspect of in-hospital treatment. With a reduction in the length of treatment by 4 weeks, over $5,000 is saved, based on a cost of $200 per day.

Diamond and Bennett[5] correlated the results of Amphotericin B therapy with laboratory and clinical findings in 111 patients with cryptococcal meningitis and established a number of prognostic factors that were used to identify high-risk patients. They found in their series that treatment results did not correlate with sex or total dose of Amphotericin B. Initial CSF findings in patients who died after completing a course of Amphotericin B were not significantly different from those values in patients who were cured. In contrast, several striking differences were found when patients died before or during therapy with Amphotericin B. Patients were found to be more likely to have had a positive India ink preparation, higher initial lumbar opening pressures, lower CSF leukocyte counts ($< 20/mm^3$), lower CSF glucose levels, anticryptococcal antibody absent, initial CSF or serum cryptococcal antigen titer $\geq 1:32$, and corticosteroid therapy or lymphoreticular malignancy.

This case is unusual in that the probable source of exposure was established by environmental studies of the patient's work area.

Our patient became asymptomatic 1 week after therapy began. Within 1 month, his CSF was negative on Gram stain and India ink study, and the CSF cryptococcal antigen titer significantly declined from 1:32 to zero, reflecting the patient's recovery. The last LP performed in the hospital on January 15 revealed only two WBCs and a normal protein and glucose. Follow-up LPs in March and July were both within normal limits with negative cultures, antigen, serologic tests, and India ink preparations.

The two specimens of pigeon droppings taken from the grain-drying building and barns were both positive. *C. neoformans* was isolated from both of the samples. Colony forming units (CFU) were counted on the isolation plates, and the number of yeast cells per gram of material was estimated at 24 million in the sample taken from the grain-drying building and 1.9 million in the pooled sample taken from the two barns. The high concentration of *C. neoformans* in the two environmental samples indicates that the grain-drying building or the barns or both were the most likely source of the patient's infection.

It is well established that *C. neoformans* is frequently present in accumulated pigeon excrement. The organism has been cultured from as many as 84% of samples from old roosting areas and less often from soil and organic debris.[6] Denton and DiSalvo,[7] in an examination of 2098 samples of soil and organic debris from the southeastern United States, found that 50% of the pigeon habitats were positive for *C. neoformans*. The patient denied having demolished old buildings, handling manure, or

having any association with bird droppings except with that which was present in the buildings at his current place of employment.

Powell et al.[3] used an Anderson air sampler to study airborne *C. neoformans* particles from pigeon excreta. They demonstrated that these particles were of a size which could result in alveolar deposition, thus supporting the hypothesis that cryptococcosis originates as a pulmonary infection.

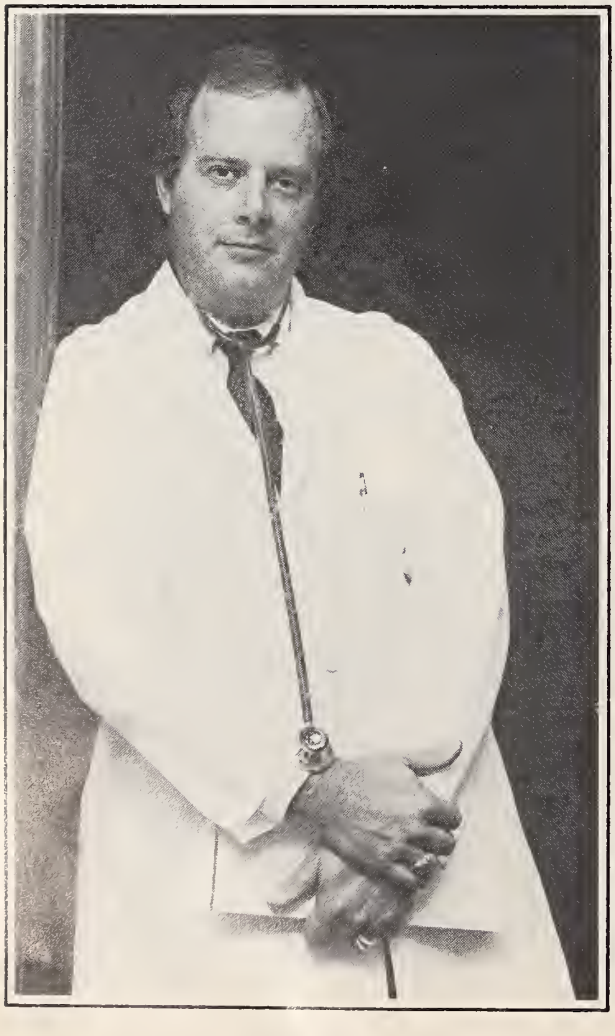
Concomitant use of antigen and antibody tests permits detection of over 90% of confirmed active cases of extrameningeal cryptococcosis.

Serum specimens from eight employees who also worked in and around the barns did not demonstrate any antibody as determined by indirect fluorescent antibody and tube agglutination tests. The sera were also negative by latex agglutination for cryptococcal antigen. Studies have shown that the concomitant use of antigen and antibody tests permits detection of over 90% of confirmed active cases of extrameningeal cryptococcosis.[2] The length of exposure ranged from 1.5 to 14 years. None of these employees worked in the upper level of the grain-drying building except the patient. This could explain why the patient became infected while the others did not.

It is difficult to identify and delineate the exposure of persons who contract cryptococcal meningitis. Muchmore et al.[8] collected environmental samples in a small town where three cases of cryptococcal meningitis occurred within 1 year. *C. neoformans* was isolated from 6 of 71 specimens. Four were droppings of pigeons and sparrows; the other two were soil samples. There was no indication that the positive samples were collected from the specific sites of exposure of the three cases. The case presented here is unusual in that the positive environmental samples appear to be related to the only known source of exposure of the case.

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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 μg/ml and 0.09 μg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	–	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	–
(range)	(70-99%)	(99.5%-100%)	–	–

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets. VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
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Quantitative immunoglobulin levels performed by radial diffusion or nephelometric technique are the mainstay of diagnosis for this group of disorders.

Antibody Deficiency Disorders

MARGARET F. GUILL, M.D., *Augusta**

HUMORAL IMMUNODEFICIENCY STATES are characterized by quantitative or functional deficiency of one or more immunoglobulin classes. Characteristically, patients with antibody deficiency have recurrent sinopulmonary infections which begin in the second half of the first year of life and respond readily to antibiotic treatment. Transplacentally acquired IgG usually provides sufficient protection for the first few months. Encapsulated organisms such as pneumococcus and *Hemophilus influenzae* are the pathogens most frequently implicated. Chronic diarrhea with frequent *Giardia lamblia* infestation is not uncommon in those with panhypogammaglobulinemia or IgA deficiency. Thus, the child seen at age 2 years with several episodes of pneumonia and purulent otitis media associated with otherwise normal growth and development would be suspect for gammaglobulin deficiency.

Quantitative immunoglobulin levels (IgG, A, M) performed by radial diffusion or nephelometric technique are the mainstay of diagnosis for this group of disorders. Protein electrophoresis and immunoelectrophoresis are semiquantitative and are not sufficient for diagnosis. Age-graded tables of norms for all immunoglobulin classes are available and should be taken into consideration in evaluating quantitative levels. In situations where levels of IgG or IgM are below normal or when deficiency in function of quantitatively normal immunoglobulin is suspected, antibody response to specific stimuli can be determined. The naturally occurring blood group antibodies are predominantly of IgM class, therefore quantitation of anti-A and anti-B will give an estimate of presence of functional IgM antibodies in all patients except those with type AB blood. Measurement of specific antibody levels before and 2 weeks after a standard booster immunization, such as diphtheria-tetanus, will help to evaluate IgG response. ASO titer is another gross measure of IgG function when there has been a recent streptococcal infection. All of these procedures are available through local, state, or commercial laboratories. Available from some research laboratories are procedures for evaluation of immunoglobulin production, including quantitation of B-cell numbers by surface immunoglobulins or other surface markers, and measurement of immunoglobulin *in vitro* after stimulation of cultured cells with nonspecific mitogens. Relative amounts of the four subclasses of IgG can also be measured. Some patients with borderline or moderately low IgG have a deficiency of a specific subgroup.

Transient hypogammaglobulinemia of infancy is an uncommon disorder representing delayed maturation of gammaglobulin production. There is a prolonged nadir and slow rise of IgG production which generally catches up to normal levels between 2 and 3 years of age. IgG levels are usually in the range of 200-300 mg%, with total immunoglobulins less than 400 mg%. Specific IgG is usually produced to antigenic stimuli, and these children rarely need gammaglobulin replacement therapy.[1]

Congenital X-linked agammaglobulinemia, described by Bruton in 1952,[2] is the classic example of panhypogammaglobulinemia with failure of the B-cell line. These males have virtually absent immunoglobulins, lack of antibody responses, and absence of B-cells in the peripheral blood and lymphoid tissue. The only significant physical findings are sparsity of lymphoid tissue, evidence of recurrent pulmonary, sinus, and ear infections, and occasionally joint effusions. Autoimmune diseases are not uncommon in these children.

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Therapy consists of replacement in the form of gammaglobulin injections (0.6-0.8 ml/kg/month) biweekly or monthly, or with fresh frozen plasma infusions (10cc/kg/month for younger children, up to 1 unit monthly), or the recently released intravenous deaggregated gammaglobulin products (3-4 ml/kg/month) to maintain IgG at 200-300 mg%. Routine immunizations are ineffective in these patients, and there have been reports of severe reactions to live polio vaccine.[3] Passive immunization is obtained from therapeutic gammaglobulin. Rigorous pulmonary toilet is often needed in addition to frequent antibiotics for prevention of progressively debilitating pulmonary disease.

Common variable hypogammaglobulinemia is a secondary panhypogammaglobulinemia frequently presenting with recurrent sinopulmonary infections. The age of onset is variable; problems may not begin until adolescence or adulthood, suggesting a late failure of immunoglobulin production. Indeed, identifiable B-cells are often present or increased in peripheral blood and lymphoid tissue, and there may be lymphadenopathy, though quantitative levels of all immunoglobulins are markedly reduced, and there is no response to specific antigenic stimulation. In some patients, suppressor T-cells interfering with production of immunoglobulin by B-cells have been identified,[4] though this has not been uniformly true.[5] There is no X-linked inheritance demonstrable. There is a propensity for autoimmune disease and lymphoreticular malignancy, further suggesting disorders of regulatory cell function. Clinical presentation and treatment are the same as for X-linked hypogammaglobulinemia.

The most common primary immunodeficiency is **selective IgA deficiency;** reported incidences range from 1:500-1:700 of the total population, many being asymptomatic.[6, 7] Because IgA is the primary immunoglobulin in external secretions, it is an important defense against respiratory and gastrointestinal pathogens. IgA deficiency is associated with both increased infection and with allergy, suggesting a role for IgA in primary defense against allergen sensitization. There is a very high incidence of autoimmune disorders and malignancies in this group. Treatment with gammaglobulin is not theoretically feasible because of the low levels and short half life of IgA in commercially available gammaglobulin preparations. Severe reactions to transfused blood products have occurred in some patients, because they are able to make IgG antibodies against the transfused IgA. However, there have been several reports of amelioration of autoimmune and gastrointestinal symptoms in IgA-deficient patients by regular plasma transfusions with no ill effects observed.[8, 9, 10] Nonetheless, IgA-deficient patients should be warned of the possibility of anaphylaxis from receiving IgA-containing blood products. Therapy remains directed towards prompt recognition and treatment of infections, good pulmonary toilet, and treatment of associated disorders.

Evaluation of Humoral Immune Function

Quantitation

- **IgG, IgA, IgM levels**
- **IgG subgroups**
- **B-cell numbers**
 - **immunologic surface markers on circulating lymphocytes**
 - **plasma cells in bone marrow**

Specific responses

- ***in vivo***
 - **IgG — diphtheria-tetanus, ASO, polio, rubella**
 - **IgM — natural isohemagglutinins**
- ***in vitro***
 - **stimulate lymphocytes with antigen; quantitate IgG and IgM produced**

There are various other dysgammaglobulinemias which occur in rare sporadic cases. These may be manifested by isolated low levels of one immunoglobulin class, with sparing of others, or by normal quantitative levels with inability to respond to specific antigenic challenge. In some cases, gammaglobulin therapy is indicated.

Secondary humoral immunodeficiencies may involve impaired synthesis related to malnutrition and malignancy (particularly multiple myeloma and some forms of lymphoma). Excessive losses of immunoglobulins may occur in nephrotic syndrome, protein-losing enteropathy, and extensive burns. Myotonic dystrophy is associated with specific hypermetabolism of IgG but normal survival of other classes. Certain viral infections have been associated with transient suppression of immunoglobulin production; infectious mononucleosis has on occasion been reported to precede the onset of common variable hypogammaglobulinemia. Amelioration of the primary disorder will often improve immune competence, though specific gammaglobulin replacement may be required in some cases.

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This case stresses the importance of communication between laboratory personnel and the patient's physician in the interpretation of clinical data.

Hemolytic Anemia Apparently Caused by Heterozygosity for Hemoglobin J-Baltimore

J. S. KRAUSS, M.D., M. H. JONAH, S.H., M.T., M. TRINH, M.T., and T. STEWART, M.D., *Augusta**

Abstract

A 26-year-old black woman entered the Eugene Talmadge Memorial Hospital for treatment of congestive heart failure. The patient died suddenly on her twentieth hospital day. Autopsy confirmed widespread sarcoidosis, dehiscence of the mitral valve prosthesis, and iron deficiency. HbA/J-Baltimore heterozygosity has not been associated with hemolysis. Hence, this case stresses the importance of communication between laboratory personnel and the patient's physician in the interpretation of clinical data. Moreover, this case also reflects the advantages of local evaluation of variant hemoglobins.

Introduction

We report an instance in which hemolytic anemia was apparently secondary to heterozygosity for hemoglobin J-Baltimore. Careful analysis of the patient's history, however, revealed a more definitive explanation.

Report of a Case

A 26-year-old black woman with widespread sarcoidosis entered the Eugene Talmadge Memorial Hospital in Augusta for severe congestive heart failure. Two years previously, she underwent a splenectomy due to sarcoid of 2 years duration for which she had been receiving corticosteroids. One year previously, she had a mitral valve replacement for prolapse and a hysterectomy. Eight months previously, she underwent a repeat mitral valve replacement for a perivalvular leak. She was taking Coumadin (warfarin sodium).

Physical examination revealed a grade IV/VI holosystolic heart murmur and hepatomegaly. Relevant admission laboratory data included a hemoglobin of 12.3 g/dl, mean cell volume 69μ^3, platelet count 200,000 per mm^3, reticulocyte count 10%, prothrombin time 28.4/10.2 sec, total bilirubin 4.0 mg/dl, 3.3 mg/dl conjugated, LDH 960 mμ/dl, SGOT 142 mμ/ml, alkaline phosphatase 222 mμ/ml, 61% heat stable. Chest x-ray was compatible with congestive heart failure. Special non-invasive cardiac studies suggested congestive heart failure, mitral and tricuspid regurgitation, and prosthetic valve malfunction. The blood smear had severe anisopoikilocytosis, microcytosis, burr cells, schistocytes, nucleated red cells, Howell-Jolly bodies, polychromatophilia, and basophilic stippling (Figure 1). Hemoglobin electrophoresis was ordered to evaluate the abnormal blood smear and microcytosis. Cellulose acetate electrophoresis* had a fast (anodal) hemoglobin, HbA, and HbA_2. An abnormal HbA_2 band

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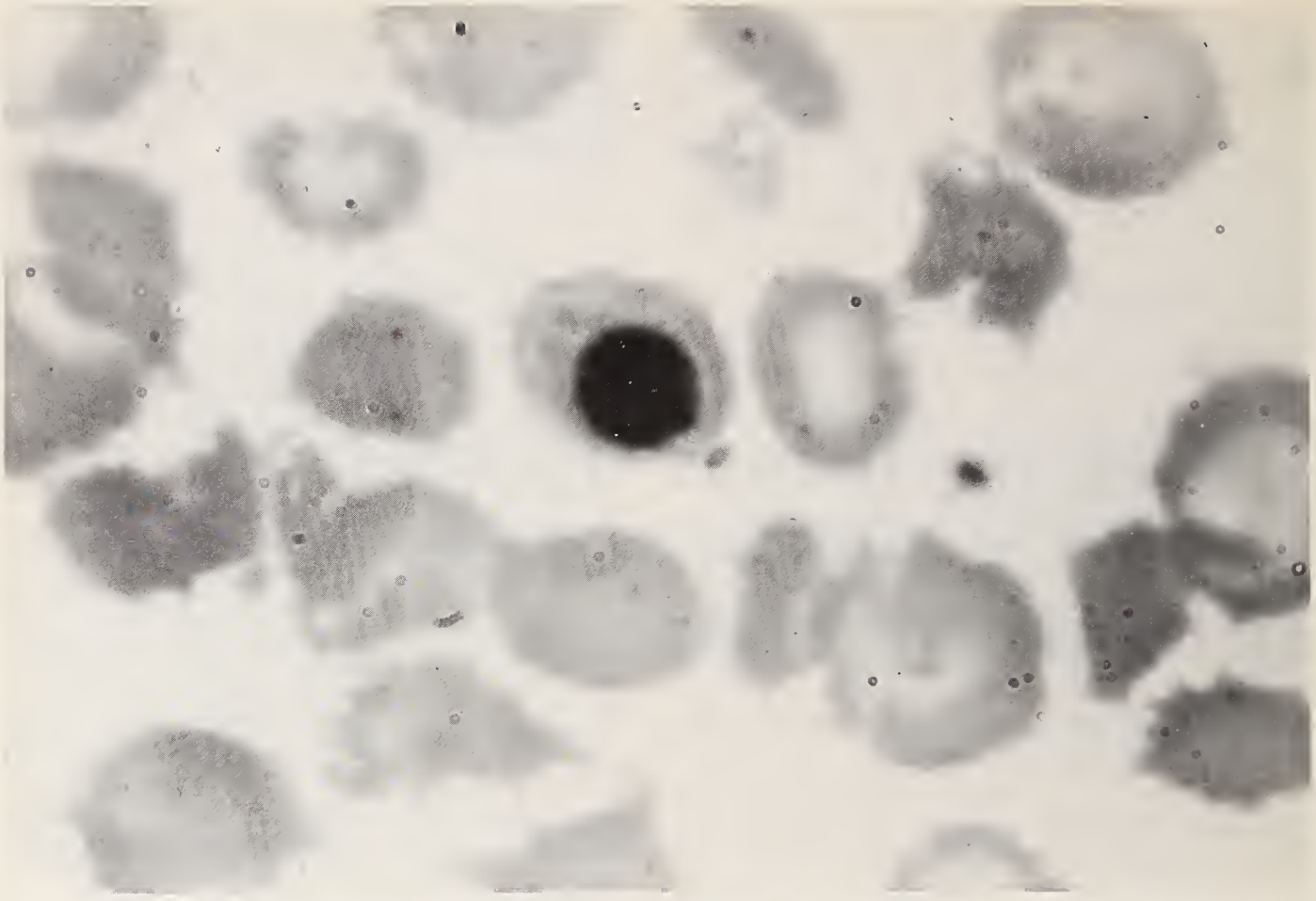


Figure 1 — 1000×. Wright stained blood smear. Note schistocytes, burr cells, and central nucleated red cell.

and HbF band were not identified. Citrate agar electrophoresis[1] had an HbA pattern (Figure 2). The fast hemoglobin composed 60% of the total hemoglobin by cellulose acetate elution.[2] HbA_2 was 2%.[2] The fast hemoglobin was identified as probable HbJ-Baltimore ($\alpha_2\beta_2^{16Gly\text{-}Asp}$).

On her twentieth hospital day, the patient suddenly died. Autopsy confirmed widespread sarcoidosis, dehiscence of the prosthetic mitral valve, and iron deficiency.

Discussion

The lack of an abnormal HbA_2 band and the high level of variant hemoglobin were consistent with a β chain mutation which was confirmed by reference laboratories as putative HbJ-Baltimore. At the time heterozygosity for a fast hemoglobin variant was reported, the patient was thought to have hemolytic anemia secondary to a "hemoglobinopathy." Heterozygous hemoglobin variants with the exception of unstable hemoglobins would not be expected to cause hemolysis. Moreover, HbJ-Baltimore heterozygosity has not been associated with hemolysis.[3] Therefore, another explanation was considered. The findings in this case were due to a combination of a "Waring Blender" syndrome secondary to the malfunctioning mitral valve prosthesis,[4] hepatic dysfunction resulting from sarcoid and congestive heart failure, splenectomy, and iron deficiency. The cause for her iron deficiency was unclear, however. While anticoagulants can cause menorrhagia and gastrointestinal hemorrhage, this patient had neither a uterus nor a guaiac positive stool. The iron deficiency was probably due to chronic hemosiderin and hemoglobinuria.

The growing prevalence of laboratory expertise in hemoglobinopathy detection suggests that the preliminary evaluation of hemoglobin variants should occur locally rather than in a reference laboratory.

Commercial kits for hemoglobin electrophoresis have become available in the past decade. Therefore, the ability to perform the preliminary evaluation of a variant hemoglobin should exist in the clinical laboratories of moderately large Georgia community hospitals. This case, then, is an example of the importance of communication between the patient's physician and laboratory personnel. Their exchange of information led to the proper identification of the cause of this compensated hemolytic anemia. The growing prevalence of laboratory expertise in hemoglobinopathy detection suggests the

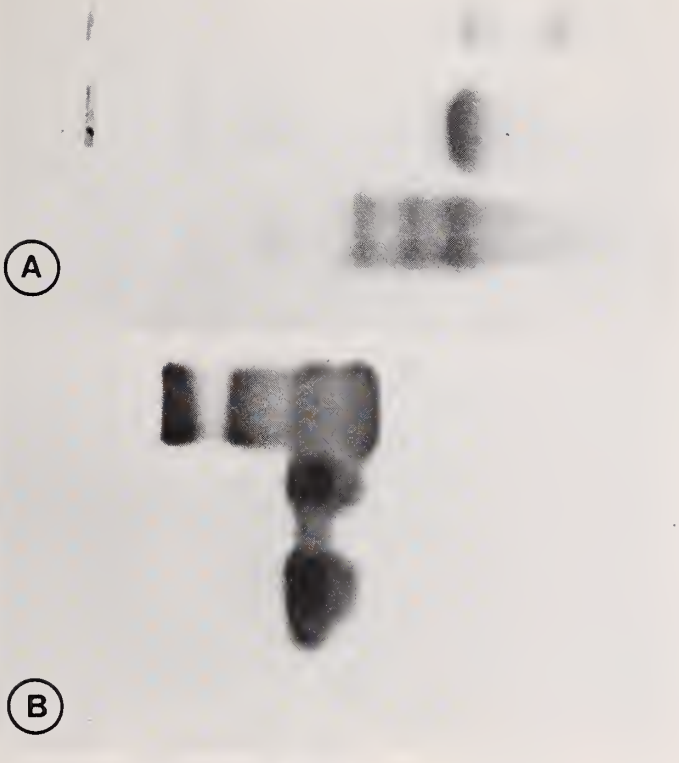


Figure 2

Figure 2 (A) (Above) — Cellulose acetate hemoglobin electrophoresis. The anode is at the right. The origin is at the left. At the bottom is a control consisting of HbsA, F, S, and A_2. Above is a normal hemolysate with an HbA, A_2 pattern. At the top is the patient's hemolysate. Note the fast dense anodal band, and the lack of an abnormal HbA_2 band.

(B) (Below) — Citrate agar electrophoresis. The anode is at the left; the origin is toward the left. Above is a central hemolysate consisting of HbsF, A, S, and C. Below are two of the patient's hemolysates, both forming a single band under HbA.

preliminary evaluation of hemoglobin variants should occur locally rather than in a reference laboratory.

Acknowledgement

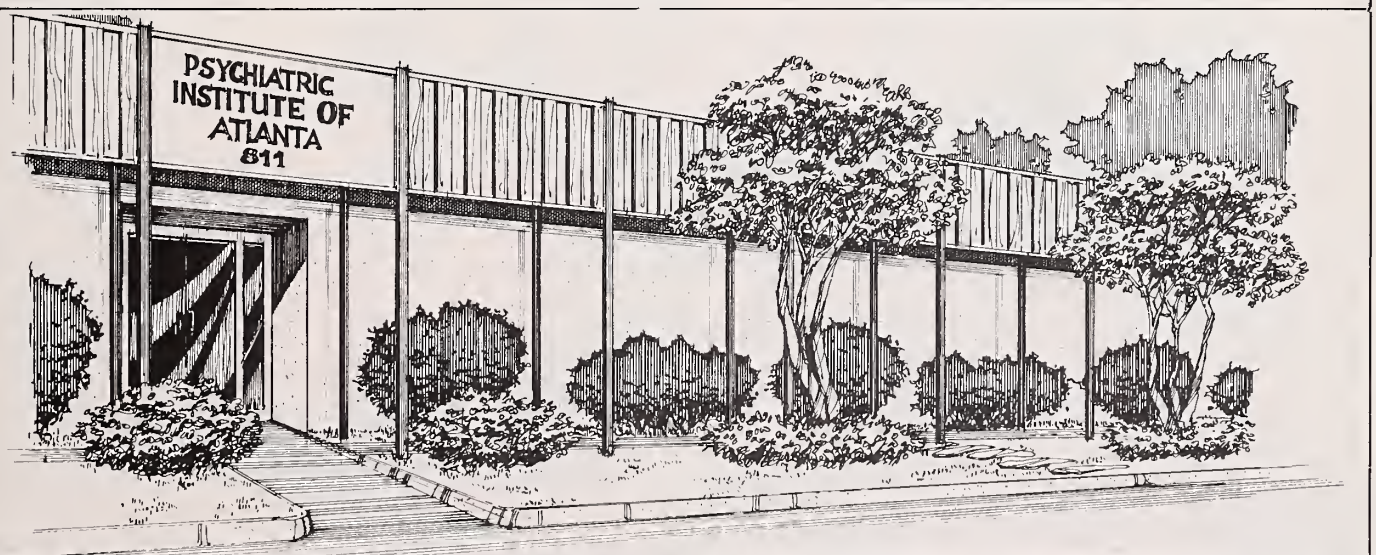
We thank Drs. THJ Huisman and WF Moo-Penn for hemoglobin variant identification.

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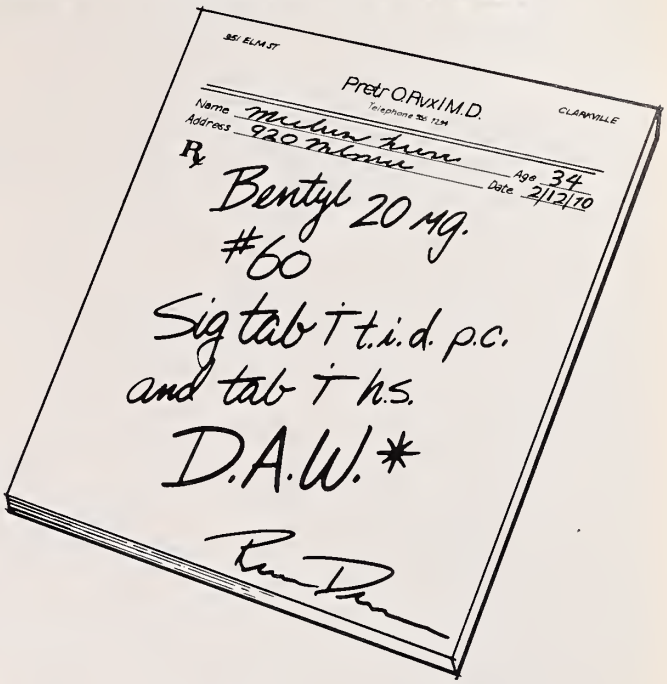
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- Significant pharmacologic effect in the distal colon compared to placebo,[1] shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

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Reference:
1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

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A look at some of the factors that have contributed to the so-called "malpractice crisis."

Why the Malpractice Crisis?

HOWARD LAMB, *Atlanta,* **and CHARLES D. HOLLIS, JR., M.D.,** *Albany**

THE MEDICAL MALPRACTICE crisis we now face is demonstrated vividly by the increasing number of claims and suits, higher jury awards, and a dramatic increase in professional liability insurance premiums. The crisis seems to have arisen, paradoxically, from the great progress of medical science in the last 4 decades and the resulting public expectation that medicine should have a cure for every ill. In addition, the attitudes of physicians themselves has gradually changed. This change in attitude has led subtly but inevitably to the crucial issue of how medical negligence is defined.

The simplest way of defining negligence is that the physician owes it to his patient to be careful. If the patient suffers injury as a result of the physician's carelessness, then liability exists. But, like most legal issues, this one is simple in theory but complex in practice.

In most states, malpractice litigation mainly involves errors of commission.

In general, both carelessness and injury must be established. In one case, a patient's lung cancer was diagnosed about a year after she began seeing a doctor. She filed suit. In court, the defense testified that the cancer was multifocal in origin and inoperable from the beginning. The jury accepted that testimony and returned a verdict for the defense.

Sometimes, carelessness may be indisputable, but no injury results. In one well known case, an obstetrician was called to the hospital late at night to perform an emergency cesarean section. He was moderately intoxicated, and when he made his initial incision he cut through the wall of the uterus and the amniotic membrane, leaving the infant exposed for a short time. This, along with the fact that he performed under the influence of alcohol, made his carelessness clear. But because there was no injury there was no basis for a negligence suit.

Negligent medical injury can be divided into two categories: errors of commission and errors of omission. The first category includes the slip of the surgeon's scalpel, the inadvertent administration of an injurious drug, the cast applied so tightly that circulation is impaired. Errors of omission are basically mistakes in judgment. If the physician had given a more effective drug, if his therapeutic intervention had been better timed, if his diagnostic skills had been a bit sharper, then the unsatisfactory outcome could have been avoided.

In most states, malpractice litigation mainly involves errors of commission. Unless a judgmental error is gross, it seldom would be the cause of a lawsuit in that locale. The reason is that physicians in those states who would have to testify still believe that "honest mistakes" should not be litigated. Therefore, expert witnesses are often hard to find.

In the few states where that attitude has changed, the incidence of successful malpractice actions has risen sharply. In these instances, there is a much higher proportion of suits in which judgmental errors are deemed to be the cause of unsatisfactory outcomes. This is especially true where there is an exceptionally high standard of care applied.

Many argue that there is no logical reason why an error of judgment should be any less subject to a malpractice action than an overt blunder. The test remains the same: did the physician meet his legal duty to the patient to be careful. The answer can get rather complex at this point, but in the real world of a jury trial, the issue is simple: did the physician violate the standard of average, reasonable care.

What is the basis for a jury's judgment? In most

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cases, the crucial evidence is testimony from at least one physician appearing as a witness for the patient. For the most part, at least one physician witness testifies for the patient and at least one for the defendant. The jury then decides, on the basis of expert testimony, what standard of care should be applied and whether the doctor violated it.

One of the most interesting aspects of medical malpractice litigation is just how standards of care are set by juries. For example, in 1973, a California jury returned a $1.5 million verdict against an anesthesiologist. The plaintiff had suffered a cardiac arrest after a brief elective operation and was left with brain damage. Her attorney presented medical testimony to support two arguments: that there were oversights in the management of the anesthesia that led to the cardiac arrest, and that if the anesthesiologist had been monitoring her pulse constantly he would have detected the arrest immediately, could have begun resuscitation, and avoided the brain damage. This second argument was central to the jury's decision.

Often by the verdicts they return in malpractice cases, juries contribute to the determination of standards of care.

During the trial, the defendant and three other witnesses testified that continual monitoring of a patient's pulse was not standard practice in that community for a simple operation. After the trial, several anesthesiologists in teaching centers said that continual monitoring was a preferred practice, but not widely enough observed to constitute a standard of care. But it does constitute the standard now, especially after three later cases involving the same issue went against the defendant anesthesiologists.

Against this background, the origins of the 1975 "malpractice crisis" are easily seen. The immediate cause was the sudden and drastic increase in professional liability insurance premiums. Professional liability insurance became much more difficult to get as commercial carriers left the market. Resistance among physicians to higher premiums often led the only company left in the state to withdraw. In 28 states, physicians subsequently responded to this "malpractice crisis" by forming their own companies.

Ultimately, the losses on professional liability insurance can stabilize, given fair determination of issues of liability, reasonable apportionment of damages, effective cost-containment legislation, and the establishment of insurance companies owned by physicians. An important aspect to the operation of physician-owned companies is the application of careful underwriting restrictions aimed at making certain that an insured physician attempts to perform only those medical tasks he can do well. It can be argued that such a system would amount to a form of licensing through insurance rather than state law. But such limitations are rational in light of the growing complexity of modern medicine. Moreover, if physicians own the insurance companies, the problem of fairness in applying limitations should be minimal.

Some physicians believe this kind of restriction will have little value, since it is generally the "technically sound, highly trained," doctor who gets sued. The general practitioner, who is likely to have a stable practice in a small community, will often escape lawsuits regardless of his mistakes. Although this generalization overlooks the numerous jury verdicts and settlements against various physicians, it contains an element of truth. The best physicians are likely to be in charge of the most difficult cases and so may be the target of more claims. Most of these claims will not result in payment, although even the best physician can be guilty of a mistake that is established as negligence by expert testimony. It is feasible to fund insurance for reasonable economic loss caused by negligent injury. But when individual awards are excessive, society as a whole ultimately pays. The time is coming when there must be some limitation set on payment for "pain and suffering." We must develop a rational system for determining facts in malpractice cases to assure that justice for both patients and physicians is achieved.

The author discusses and offers some solutions to the "family-type" interactions and conflicts in the office that can interfere with the proper functioning of the group.

Is There Trouble in Your Office Family?

ALFRED A. MESSER, M.D., *Atlanta**

I HAD LUNCH recently with a pediatrician, who came in looking harassed.

"My practice is busier than ever," he said tiredly, "but I seem to be spending more of my energy settling staff disputes, energy that could be used for my patients. Just as I was leaving for lunch, the nurse asked me to speak to the technician. She feels lab reports should be delivered to her one by one as soon as they're completed."

Office problems have interested me for many years. Industrial psychiatry has been my subspecialty, and I do occasional consultations in factories and business offices, as well as treat the typical executive or professional suffering from job-related stress.

"Office families" have many of the same characteristics as the natural family unit. People who work in a warm, friendly atmosphere and who look forward to going to work do a better, more efficient job. Even the terminology used in the working world reinforces this: large companies refer to their employees as members of the "corporate family," and the desired office arrangement, for doctors and everyone else, is almost always described as "one big, happy family."

In office families, someone fills the emotional role of father, mother, various siblings, and other relatives. In the medical office, the physician is usually the symbolic father (or mother), the senior nurse is the symbolic second parent or older sister, the secretary, technician, and clerk occupy sibling or other children's roles.

* Dr. Messer practices psychoanalysis and family therapy at Northside Hospital in Atlanta. Send reprint requests to him at 801 Douglas Rd., NE, Atlanta 30342.

Our Universal Needs

The family unit shares goals and identity, and provides for the physical and emotional needs of its members; love, understanding, sympathy, and patience are but a few of these universal needs. If these needs are not satisfied, the individual may pout or sulk temporarily, like a child; agitation usually accompanies this regression, sometimes with aggressive behavior.

At home, this momentary regression causes no major disturbance; it is part and parcel of family life. The family has a past, present, and future; they know from experience that the storm will blow over. But when regressive behavior occurs in the context of an artificially formed family, watch out! Sometimes "family-type" interactions and conflicts in the office become so prevalent they interfere with the proper functioning of the group.

For example: when the doctor must tell his staff that the office will not observe a particular holiday, he must remember that he is talking of business and professional concerns. He is *not* a father giving his family the unwelcome news that their rafting trip is cancelled, even though the dismayed faces of his employees may make him feel that way.

When five or six people work closely together, their formal, or business, roles become blurred. They arrive at work about the same time, take coffee breaks together, sometimes eat lunch as a group, and spend a lot of time talking about job expectations, dissatisfactions, and family life. This is the setting in which the doctor or head nurse becomes a symbolic parent. They already know so much about the personal lives of the staff, they are the natural persons to go to with a problem. Too close an identification

with these role models can result in exaggerated dependence and wasted time and money. Frequently, office efficiency is impaired.

Family Reactions

Children at home experience a natural sibling rivalry. They measure themselves against one another: who dominates, who is submissive, who is better in school, and who can wrestle the other to the ground. This rivalry is practice for competing in the world outside.

''Sibling rivalry'' in the office may also take the form of competition, for reputation of ''best'' worker, the person who stays the latest, who takes work home, etc. Every office manager would probably view these competitive reactions as no problem. Usually, though, the competition takes on a more negative aspect.

I visited my pediatrician friend's office after lunch and met his staff. The interaction between his secretary and insurance clerk was notable. Sharon, the vivacious secretary in her 20s, regaled the staff with stories about her numerous dates and boyfriends. The effects of her talk on Kate, the clerk, were obvious: she hunched over her work, trying not to listen. But her efforts were to no avail; Kate's agitation showed in a tense facial expression.

Later, I asked the pediatrician how many patients had complained about being billed incorrectly or whose insurance forms were late. He looked at me in surprise, and asked, ''How did you know? In the past 6 months, several patients have complained about overcharges. I don't know what's come over Kate — she used to be so meticulous.'' It wasn't coincidence: Sharon had been hired about 7 months ago.

Though psychiatrists with only one employee do not have to worry about sibling rivalry, their problem is that correcting one staff member is tantamount to chastising an unruly child.

In other offices I have visited, when the symbolic mother talked glowingly about her children at home, the ''office children'' became envious. They tried to regain her attention in a number of ways, each person outdoing the other. If this occurs in your office, the tensions that result can reflect badly on you when they surface in scant attention or discourtesy to your patients. As with the natural family in the home, members of the office family may excel in one area or another, and all can enjoy the success of each member. Cooperation rather than competition and rivalry is the desired reaction.

Most psychiatrists have a rather different problem; with only one employee, they do not have to worry about sibling rivalry. Their problem is that correcting one staff member is tantamount to chastising an unruly child. There are not other ''children'' around to share the reprimand, and there is no one with whom to commiserate.

Coping With Conflict

Conflicts abound in the natural family; prolonged conflict may cause continual fighting and rebellious behavior. Everyday tensions can be discharged that way. In other instances, one member may withdraw and become a loner. Or, one member may be designated as the rebel (scapegoat), and he or she is blamed for all the family unhappiness. In some families, one person acts as the perpetual ''healer,'' settling disputes whenever they get out of hand. If the doctor is constantly thrust into this healer role in his family at home, his creative energies are sapped.

Office personnel act out these roles, too. Perhaps the technician is known as the troublemaker who upsets the peace and tranquility of the office. The drawback of having a scapegoat is that it lets everyone off the hook; instead of uncovering causes of conflict and seeking appropriate solutions, the matter is handled by blaming.

Families also cope with conflicts by aligning themselves into coalitions. Father and son may align themselves against mother and daughter during a quarrel. This scene may be repeated when further stress arises, and soon the two camps find themselves arguing again. Are there little cliques in your office that carry on the same way, two against two or three against three? One exasperated doctor told me, ''Sometimes my employees shift alliances so often I almost feel like firing the whole crew!''

When conflicts arise in the office family, the glue that binds is not as strong; the same feeling of past, present, and future is missing.

How about family myths? In one natural family, an alcoholic uncle brought shame to the family, and a myth evolved: ''In our family we never touch a drop of alcohol.'' By invoking that myth, the family was spared the task of dealing with the anxiety that any member might repeat the uncle's experience.

Are there myths in your office? Many offices have a specific one — that no one challenges a managerial decision. The trouble with this myth is that decisions go unchallenged when airing a conflict could bring relief to the situation. And in this climate, many employees are unwilling to offer suggestions for constructive change in procedure.

How should we handle office conflicts? The best way is to prevent them, and here *structure* is the byword. Structure can correct or prevent many problems caused by runaway emotions.

I have often suggested that offices conduct regular

staff meetings where business and professional roles are redefined in a number of ways. Everyone can have his or her say in order of rank and position. Work problems are aired, and it is a good way to formalize relations. Such meetings, held once a month, should be scheduled during the working day. If they must be held after hours, attendance should be compensated, based on a pro-rated hourly wage for salaried employees. No one should be excused from the meetings except under extraordinary circumstances. This makes the meeting an integral part of the job.

Public commendations may be given at staff meetings, to let everyone know that good performance is noticed and appreciated. And it is also a good time to talk about the goals of improved patient management, stressing the patients' welfare and the office as a pleasant, efficient place for them to come.

In office families, someone fills the emotional role of father, mother, various siblings, and other relatives.

Additionally, it is a good idea for doctors to take lunch with their colleagues, rather than eat with employees. Office staff should follow suit, going out of the office whenever possible. These lateral moves allow everyone a break from their co-workers and redefines work roles as well. Naturally, there can be no hard and fast rule, and your own judgment will dictate in such matters.

The doctor has a built-in mechanism to help his staff understand the fact that human beings form families wherever they go: in schools, churches, on athletic teams, and in the office. A sick patient comes to the doctor to have his pain relieved, his infection cleared up, a cure affected by "magic" if necessary, and he tends to put the doctor and staff in a parent role to that end.

In any doctor's office, the majority of patients want to lean on the physician and staff just as children want to depend on their elders. The doctor can point out that the same phenomenon occurs in the medical office among the staff themselves, using the examples of reactions and coping mechanisms enumerated above. My pediatrician friend could casually tell Sharon and Kate that they sometimes act like rivalrous sisters. When Sharon overdoes her descriptions of dates and boyfriends, Kate's envy and anger subconsciously affect her work. (He has subsequently done this and has reported the situation greatly improved.)

This situation presents in a different way for the psychiatrist. In most other specialties, a physical symptom brings the patient in and along with the need for diagnosis, there is a need for emotional dependence. The patient in psychotherapy, however, may have a primary need for emotional dependence, both from the physician and his or her staff. In many of my colleagues' offices, patients will spill out their problems to the office employee while waiting to see the psychiatrist. (My nurse tells me that her friends and even strangers will reveal intimate details of their lives when they learn that she works for a psychiatrist; she is considered an extension of me.)

Educating the staff about family-type reactions in the office may not always do the job. As a last resort, the symbolic parent must sometimes be able to tell a pouting or rebellious employee, "Look, I'm not your father (mother). We have a job to do. Let's get on with it." This statement may temporarily shake up that employee, but it reinforces professional roles and tells the person (and others) that regressive behavior is undesirable in the practice of medicine.



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editorial
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FTC and the Professions: Let's Tell Congress Our Views

THE ISSUE of the Federal Trade Commission's assumed jurisdiction over the professions may soon be settled by the Congress.

The decision is important not only for us as physicians but also for our patients. At stake for the medical profession is our right to set standards to protect the public from deception and incompetence in the medical profession. At stake for individual states is the right to enact laws pertaining to professionals and professional organizations without threat of having them preempted by a nonelected agency. At stake for patients is their right to have qualified and experienced medical professionals responsible for professional self-regulation that embraces a commitment to serve the public and improve the quality of life in our society.

The physicians of America are not asking for exemption from the antitrust laws. We are asking that claims of improper conduct by professional groups be tried in courts with impartial judges — not in administrative hearings before salaried employees of the agency making the charges.

We are asking that the FTC be required to respect duly enacted state laws. And we are asking that the Congress clarify that it never empowered the FTC to regulate not-for-profit professional organizations.

Before the Congress are legislative proposals that agree with our position. They deserve the support of every physician in this country. And our legislators need to know that we support these proposals and why. The FTC is at the center of congressional attention because its authorization expires at the end of this fiscal year, so action may be expected soon.

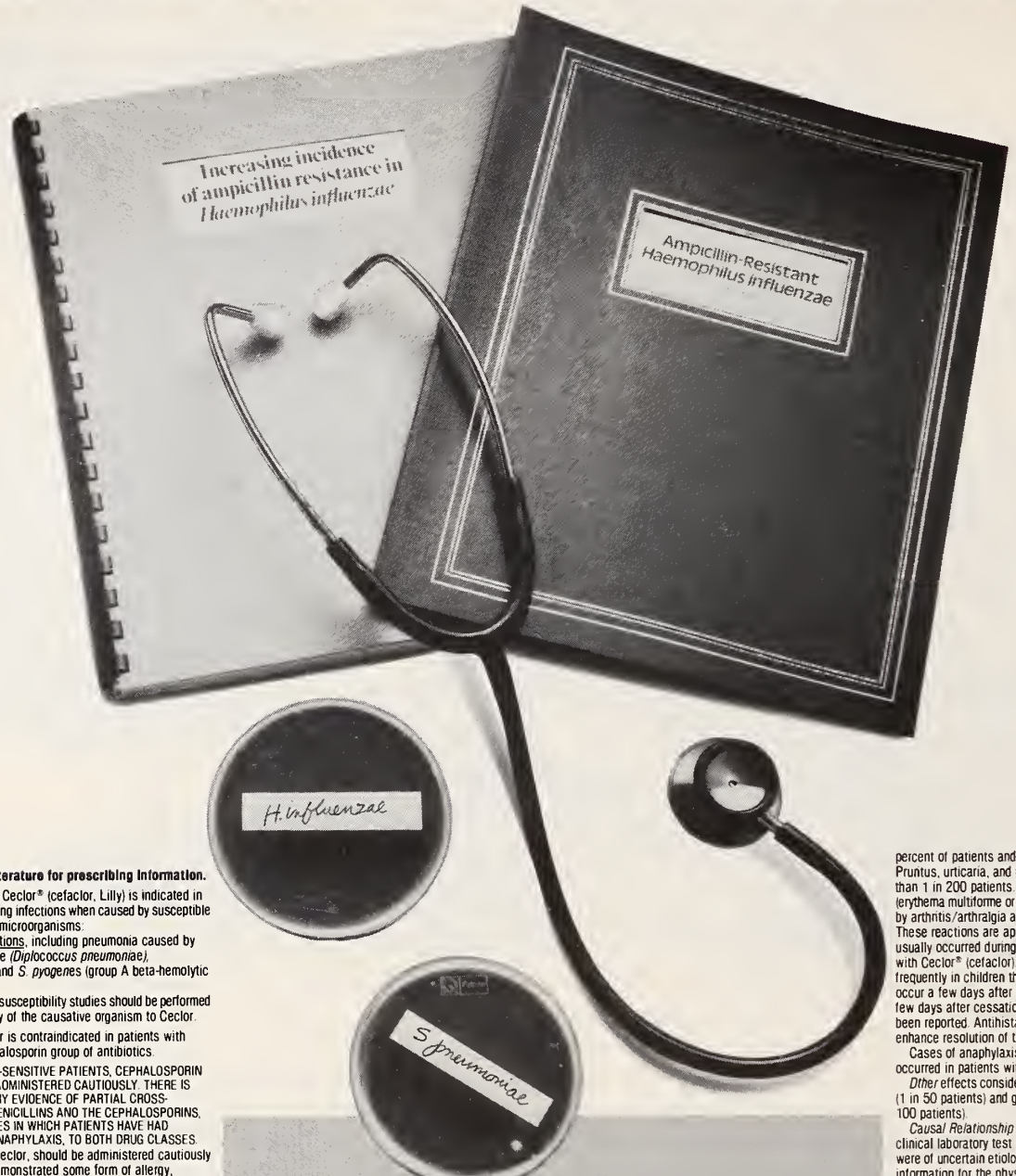
The two principal bills in the Senate are S.1984 and S.2499. S.1984 would amend the FTC Act to clarify that there is no FTC jurisdiction over the professions, prohibit FTC preemption of state laws, and make major procedural changes in FTC proceedings. S.2499 would, among other changes, define unfair acts or practices, prohibit FTC preemption of state laws on scope of professional practice of state-licensed professionals, and extend the congressional veto power on trade regulation rule provisions. That bill, with an amendment clarifying that the FTC has no jurisdiction over state-regulated professions, has been voted out of committee and will go before the full Senate.

In the House of Representatives, H.R.3722, which has 181 cosponsors, would place a moratorium on FTC activities regarding state-regulated professions and professional associations.

The vital question of whether the FTC will be allowed to continue its self-appointed role of regulator of the professions will soon be decided. Write, wire, or phone your senators and representatives and give them your views. Those few minutes you spend could help them make correct decisions affecting our professional future for many years.

Charles D. Hollis, Jr., M.D.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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Cancer Prevention Study II

CHARLES R. UNDERWOOD, M.D., *Marietta**

OUR LIFE-STYLES can put us on a collision course with cancer. But in the interlocking complexities of modern life, it is often difficult to pinpoint which habits and choices are truly the risky ones — which ones to avoid or amend to escape cancers. Just what are we doing that invites or prevents cancers? What turns healthy body cells into cancerous ones, following their own irresponsible destiny? Some risks are well documented: cigarettes are a prime example.

In September, 1982, the American Cancer Society (ACS) is initiating a huge new research program, Cancer Prevention Study II (CPS-II), to identify other risk factors. A small army of 100,000 ACS volunteers will soon begin enlisting more than 1,000,000 persons throughout the country. In Georgia, 30,000 persons will be interviewed by 3,000 volunteers. The volunteers will invite them to answer some 400 items in a confidential questionnaire about what they eat and drink, how they work and live. Then, for at least 6 years afterward, these "research volunteers" will keep track of what happens to these million Americans, reporting to ACS Headquarters whether they are alive or have died. Health statisticians then can learn how their life-styles affected their health.

The First Cancer Prevention Study

A similar Study was begun in 1959, called Cancer Prevention Study I (CPS-I). This massive statistical Study similarly involved an investigation of the life-styles of one million individuals throughout the country and was conducted by 70,000 American Cancer Society volunteers. The initial Study covered the period 1959-1965 and was updated in 1971 and 1972. It continues as an ongoing study and currently has an amazing 98% follow up.

An interesting and somewhat unanticipated benefit from this first Study has been the opportunity to observe persons with unusually long lifespans. Approximately 4,000 of the original one million people are still alive — they are all over 90 years of age. Many are more than 100 years old. They constitute an interesting group to study for those factors relating to longevity, irrespective of the development of malignant disease.

Of even greater importance were those findings from CPS-I that related to the etiologic significance of smoking in relation to the development of lung cancer as well as of cancer of the digestive tract and bladder. The relationship of smoking to heart disease and chronic lung disease was further clarified by this Study. Other important results included a better understanding of the relationship of excess weight to the development of uterine and ovarian cancer in women as well as of the relationship of excess weight gain in men to the development of carcinoma of the

* Dr. Underwood is a general surgeon and Chairman, Board of Directors, American Cancer Society, Georgia Division. Send reprint requests to him at 641 Church St., Marietta, GA 30060. Prepared at the request of the American Cancer Society, Georgia Division.

colon, rectum, and prostate; the familial link in breast cancer; the protective effect of exercise in the development of heart disease and the prevention of stroke. And finally, CPS-I gave impetus to the writing of some 65 scientific papers investigating many aspects of not only malignant disease but also other health problems.

Projected Aims of CPS-II

And now CPS-II is about to begin. A somewhat similar study, it nevertheless was carefully redesigned to explore several areas of change which have developed since CPS-I. The need for this second Study is mandated by the changing environment in which we live. CPS-II will investigate, among other things, the effects of hair dyes, plastics, exposure to low-level radiation, water and air pollution, occupational exposures, "passive smoking," including exposure to cigarette smoke in places other than at home with a smoker, and the possible role of many foodstuffs.

Were it not for the ACS volunteers contributing many hours of their time, interest, enthusiasm, shoe leather, and energy, the cost would be enormous, more than $100,000,000, (a sum likely out of reach for a single project *even* for the federal government). The ACS is probably one of the only volunteer health organizations in the world capable of carrying out the project.

CPS-II is, in one sense, an effort to share the "passion and action" of our time in an effort to live better and healthier lives in the future.

Even so, CPS-II will cost some $13 million dollars over the 6 years of data collection, for extra clerical work, computer services, record keeping, and analysis of many millions of facts and observations. The ACS is seeking special contributions to cover this direct cost of the Study, so it will not have to reduce its ongoing support of scientific research into causes and controls over cancer.

Sampling a wide variety of people from urban and rural settings, CPS-II aims at enrolling a minimum of 100,000 black men and women, since blacks now appear to run higher risks of certain forms of cancer. Only 25,000 were enrolled in the first study. Another example of a special group to be studied is the Church of the Latter Day Saints, which is thought to have a lower incidence of malignant disease than the population at large.

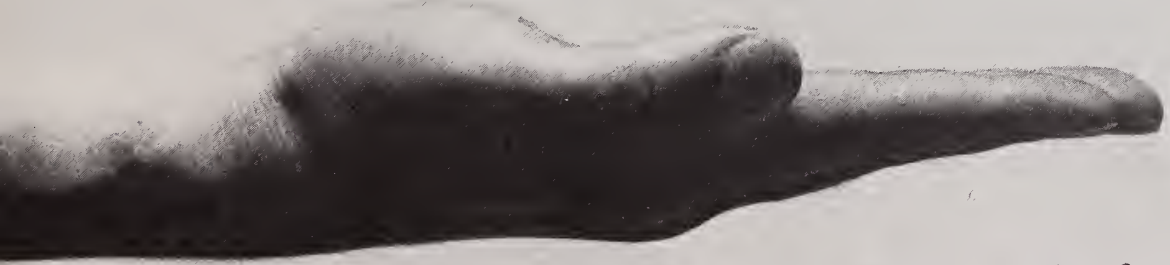
With the expenditure of so much time, effort, and money, one might still question the validity of such a study even in the light of the increase in known carcinogens in our environment. The answer to this depends on the person and involves his or her particular view as to the rightness of investigating society's life-style. One answer might come from asking whether or not the information from CPS-I that relates to such things as the hazards of smoking has been of value to society. The Study may tell us things that we do not care to know — that closely regarded habits of living and working are hazardous to our health and can be continued only at risk or can be altered for the gain of greater assurance of good health in the future. Not to conduct such studies and not to accept the reality of change in our world is perhaps to ignore the advice of Oliver Wendell Holmes, Jr., who cautioned us in 1884: "I think that, as life is action and passion, it is required of a man that he should share the passion and action of his time, at peril of being judged not to have lived."

CPS-II is, therefore, in one sense, an effort to share the "passion and action" of our time in an effort to live better and healthier lives in the future.

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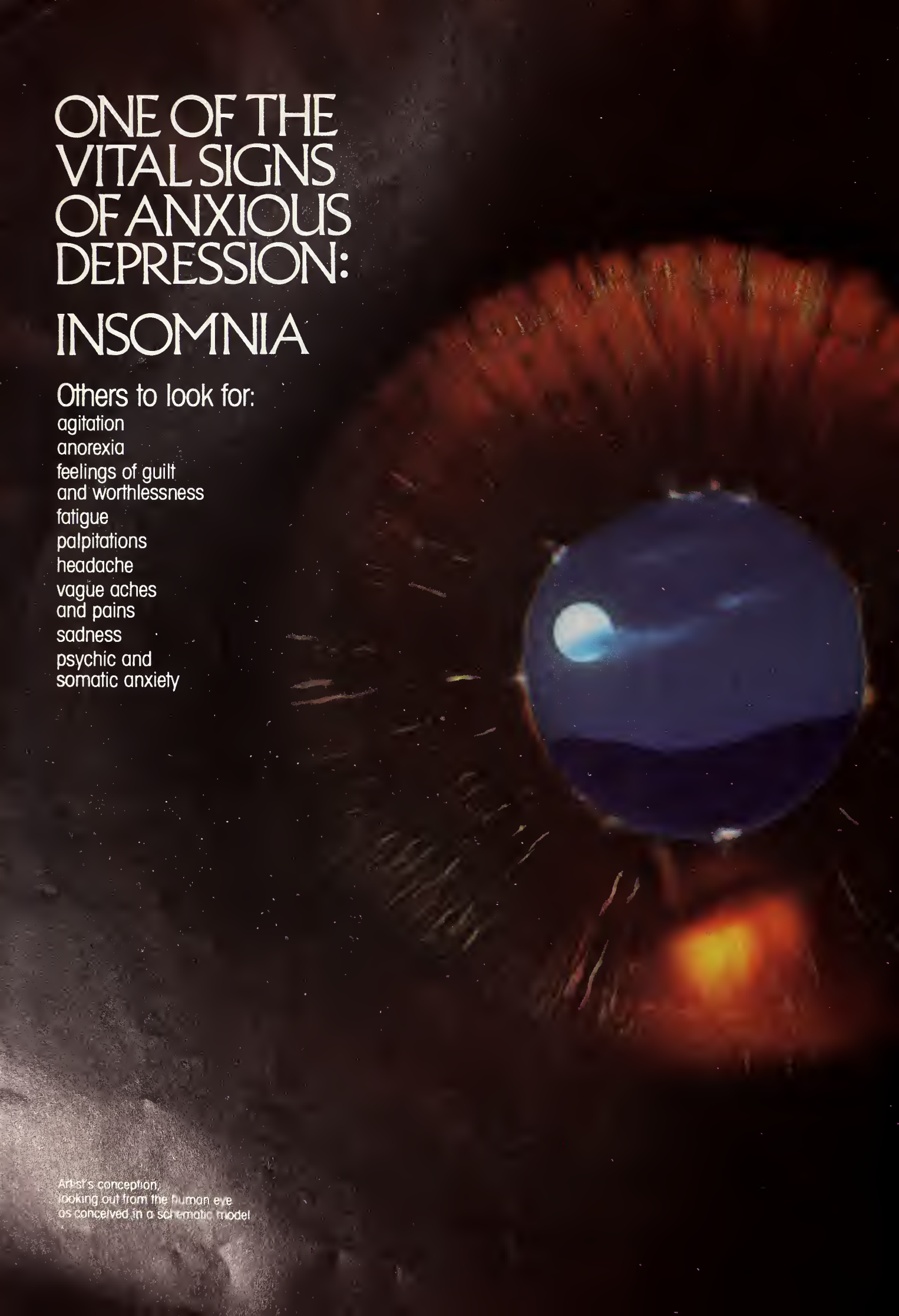
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feelings of guilt and worthlessness
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headache
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sadness
psychic and somatic anxiety



Artist's conception, looking out from the human eye as conceived in a schematic model

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Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

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Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
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heart page
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Isometric Exercise Testing in Diagnostic Cardiology

MILTIADIS A. STEFADOUROS, M.D., *Augusta**

ISOMETRIC EXERCISE is a form of exercise during which the contracting muscles develop force while their length remains unaltered. Several common physical activities such as lifting, holding, or pushing heavy objects, working with arms raised overhead, or simply standing still, involve primarily, if not exclusively, isometric exercise. Although the precise mechanism involved is not completely understood, this form of exercise consistently induces profound hemodynamic changes.[1] Thus, in both normal and diseased hearts, isometric exercise results in modest elevation of heart rate and significant elevation in arterial systolic, diastolic, and mean blood pressure, in proportion to the strength of contraction expressed as a percentage of the maximal voluntary isometric contraction that the exercising muscles can develop.

Despite the apparent similarity in the end-result, there are important differences between normal and diseased hearts in the way arterial blood pressure is raised during isometric exercise. In the normal heart, left ventricular (LV) end-diastolic volume, end-systolic volume, stroke volume, and ejection fraction remain unchanged during isometric exercise.[2] The cardiac output increases by virtue of the increase in heart rate, thus resulting in an elevation of blood pressure in the presence of unchanged systemic vascular resistance.[2, 3] In addition, the product of mean systolic blood pressure and stroke volume (stroke work) increases substantially during isometric exercise at a minimal or no cost in terms of the LV filling pressure (pulmonary capillary pressure) which remains practically unaltered or even falls.[3, 4] In contrast, patients with latent or overt LV dysfunction, as well as some elderly but apparently normal subjects, respond to isometric exercise by an increase in heart rate and end-systolic volume, a decrease in stroke volume and ejection fraction, and an elevation of blood pressure brought on primarily by marked elevation in systemic vascular resistance with unchanged or mildly raised cardiac output. In these patients, the stroke work usually falls or remains unchanged during isometric exercise despite a substantial rise in LV filling pressure. Thus, in both normal and diseased hearts, isometric exercise results in increased LV afterload and, hence, myocardial oxygen requirements.[5] If proportional increases in regional coronary blood flow and myocardial oxygen supply are prevented by existing critical coronary stenotic lesions, myocardial ischemia, angina and/or ventricular dysrhythmias may ensue.

The usual form of isometric exercise employed at the bedside, the handgrip test, requires the use of a small, inexpensive instrument (dynamometer) which the

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Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this Page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

patient squeezes with his hand while his effort is read on a scale in kilograms. The patient is initially requested to momentarily squeeze the instrument's handle as hard as he can in order to determine his maximal voluntary contraction. The actual test requires the patient to perform at a given percentage of his maximal voluntary contraction for a length of time that is inversely proportional to the level of effort (e.g. 20%, 50%, or 70% of maximal voluntary contraction for 5, 3, or 1 minutes, respectively), or until exhaustion, under continuous electrocardiographic monitoring and frequent blood pressure measurement and cardiac auscultation. For specialized studies, the LV echogram, phonocardiogram, and either the indirect carotid pulse or the apexcardiogram can be easily obtained and recorded throughout the test to determine the effect of isometric exercise on LV cavity dimensions, regional and global LV wall motion, LV function indices, and the new appearance of gallop sounds or murmurs.

The isometric handgrip test obviously requires a good amount of motivation and cooperation on behalf of the patient and is particularly useful in patients with certain physical disabilities or other limitations which preclude the use of dynamic exercise on a treadmill or bicycle ergometer. A third form of stress testing, roughly equivalent to isometric exercise, is the intravenous infusion of vasopressor drugs (e.g. angiotensin) as a means of raising blood pressure and, hence, afterload.[6] With regard to the appearance of potentially hazardous complications during the test, isometric exercise has the advantage of prompt disappearance of its cardiac effects and restoration of normal LV loading conditions upon termination of effort, as opposed to the more gradual dissipation of the hemodynamic effects of treadmill exercise or angiotensin infusion.

Despite the aforementioned advantages, isometric exercise has not found extensive use as a routine diagnostic method for detecting coronary artery disease or for evaluating LV function except for patients unable to perform on a treadmill due to various physical limitations. This may be due, at least in part, to the fact that the overall stress on the heart effected by isometric exercise is less than that induced by dynamic exercise, except for the mean blood pressure response which is more vigorous with isometric exercise, thus leading to a larger number of false negative results (decreased sensitivity). Another factor explaining this lack of popularity of isometric exercise is its potential risk for development of serious arrhythmias,[7] excessive elevation of blood pressure in severely hypertensive patients or major cerebrovascular accidents in patients with vascular malformations of the central nervous system. At the bedside or in a cardiac noninvasive laboratory, isometric exercise represents an excellent diagnostic maneuver for determining by auscultation or phonocardiography the nature and origin of certain murmurs.[8] Thus, systolic murmurs due to mitral regurgitation or small ventricular septal defect, as well as the diastolic murmurs of aortic regurgitation and mitral stenosis, generally increase in loudness during isometric exercise as opposed to systolic ejection murmurs of aortic stenosis or hypertrophic cardiomyopathy which either decrease in loudness or remain unaffected.

In conclusion, isometric exercise is an alternative, physiologic method of stressing the heart for diagnostic purposes. Far from being perfect, isometric exercise has a place in diagnostic cardiology but its profitable use depends on an understanding of its usefulness and limitations.

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Allrid v. Emory University: Applying Georgia's Medical Malpractice Statute of Limitations in a Difficult Case

MARK GOODMAN, *Atlanta**

BY LIMITING the period of time within which lawsuits must be brought, all statutes of limitation are expressions of public policy that "the right to be free of stale claims in time comes to prevail over the right to prosecute them."[1] Applying this principle can be difficult in particular instances, as a case recently decided by the Georgia Supreme Court illustrates.

The Factual Issues

In 1956, the plaintiff began having a series of convulsions which placed him near death. He was admitted to the defendant hospital, where he underwent a cerebral angiogram. On the right-side study, the hospital staff physician used the non-radioactive contrast medium Diodrast, and no abnormalities were indicated. The hospital chart for the left-side study was unclear as to the contrast medium used, but the study revealed a severe obstruction in the plaintiff's brain. The physician operated on the plaintiff and stopped the convulsions, saving the patient's life. According to the plaintiff, from 1956 to 1979, he suffered from sore throats, but his physicians were unable to determine the cause.

In 1979, the plaintiff was admitted to another hospital in Atlanta, and there his doctor determined that it appeared that the plaintiff had received Thorotrast (a radioactive contrast medium) in the left-side cerebral angiogram. The plaintiff then brought suit against the first hospital and the drug manufacturer, alleging that their combined acts of negligence were the proximate cause of his injuries. After the plaintiff died of cancer (alleged to have been caused by the Thorotrast), his widow continued the action on behalf of the deceased's estate.

The Legal Issues

The trial court dismissed the plaintiff's claim on the ground that it was barred by Georgia's medical malpractice statute of limitations. On appeal, the Georgia Supreme Court upheld not only the specific result but also the medical malpractice statute of limitations itself against a variety of legal attacks.

The Application of the Medical Malpractice Statute of Limitations to this Particular Case — Georgia's current statute of limitations for medical malpractice actions was enacted in 1976 and provides that an action for medical malpractice must be brought within 2 years after the date on which the negligent act *occurred*.[2] Clearly, the plaintiff could not recover if the current statute were applied to his

* Prepared at the request of the Medical Association of Georgia. Mr. Goodman is a summer associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

case, since the alleged negligence occurred more than 20 years before suit was brought. Moreover, the plaintiff would have fared no better if he tried to proceed under the statute of limitations in effect in 1956, which required suits to be filed within 2 years "after the cause of action accrued." If the plaintiff claimed that his cause of action accrued at the time Thorotrast was allegedly used in the angiogram in 1956, then his claim would also be barred because his suit was initiated more than 2 years after the date on which the right of action accrued.

Alleged Failure to Remove Foreign Object — The plaintiff attempted to circumvent this result in several ways. Initially, he relied on an exception to the 2-years-from-the-negligence limit provided by the current medical malpractice statute of limitations. The exception is that in cases in which a foreign object has been left in a patient's body, a malpractice action may be brought within 1 year after discovery of the wrongful act. The plaintiff asserted that the drug used by the physician in his cerebral angiogram was a "foreign object" in his body, thereby falling within the exception in the medical malpractice statute of limitations. This claim was unsuccessful, however, since the special statute contains a provision specifying that a "foreign object" does not include a chemical compound.[3]

The Supreme Court's ruling that the physician was not an agent of the hospital suggests a willingness on the part of the courts to view the relationship between the hospital and its staff physicians as one of employer-independent contractor, rather than employer-employee, as a matter of law. . . .

Alleged Constitutional Violations — The plaintiff also contended that the medical malpractice statute of limitations was violative of the equal protection of the laws because it arbitrarily provided a separate statute of limitations for actions where a foreign object was left in a patient's body. The Supreme Court ruled otherwise, holding that the distinction had a rational relationship to the governmental interest sought to be protected. According to the Court, leaving a foreign object in a patient's body was more than ordinary negligence, as it did not involve professional diagnostic judgment or discretion, which the administration of a drug required, and thus should survive the statute of limitations. "The physician's failure to remove [the foreign object] goes beyond ordinary negligence so as to be classified by the legislature as a continuing tort which tolls the statute of limitations. The foreign object in the patient's body is directly traceable to the doctor's malfeasance,"[4] and the statute of limitations should not begin to run until the object is discovered.

The Court also rejected the plaintiff's argument that the statute of limitations for medical malpractice denied him due process of law by preventing him access to the court. The essence of statutes of limitation themselves is to preclude suits from arising after a certain period of time so as to thwart stale claims. Statutes of limitation prevent plaintiffs from waiting until the evidence has disappeared, or people's memories become vague, and then bringing their suit. In this case, the person who really knew what medium was injected, the neurosurgeon, had died well before the suit was filed, and the staff doctors at the defendant hospital did not have clear recollections of what occurred in 1956. Thus, while the Court acknowledged the harshness of applying the special statute of limitations so as to cut off rights before there is any knowledge of injury, the Court nonetheless felt constrained to reject this assertion of the plaintiff.

Alleged Fraud by the Doctor — The plaintiff also tried to avoid having the medical malpractice statute applied to him by asserting that the physician committed fraud in his treatment. Under Georgia law, if the defendant (in this case the hospital) commits fraud in the cause of action, then the period of limitation runs only from the time of the discovery of the fraud.[5] The trial court held that if the

physician knowingly injected the plaintiff with a potentially hazardous substance and failed to warn him of the danger, then this would constitute fraud which would prevent the statute of limitations from being implemented.

The trial court found as a matter of law, however, that the physician was not an agent of the hospital, and hence, the hospital could not be held liable for the physician's acts, and the medical malpractice statute of limitations still applied. For the hospital to be held responsible for any negligence attributable to the physician, it had to have the right to control the time, manner, and method of the physician's work. The Supreme Court recognized that the physician, while on the active staff of the hospital, had no contract with the hospital, was not paid by it, had no insurance with it, and *rented* office space from it. The staff physicians were also generally unsupervised by the hospital in bringing in different drugs, both experimental and regular, for use on patients, and there was no regular drug administration procedure to which the physicians had to conform. Even though physicians were required to attend staff meetings, the Court determined that the combined factors indicated that the hospital did not have the right to control the time, manner, and method of the physician's work. Thus, the Court agreed with the trial court that the "uncontroverted evidence" established that the physician was not an agent, and there was no need for a jury to determine this issue.

Alleged Fraud by the Hospital — Finally, the plaintiff argued that the hospital itself committed a fraud on the patient by failing to inform him of the risks involved in using a radioactive contrast medium. However, the Court ruled that the hospital was not under a duty to disclose to the patient that a dangerous substance had been used in performing the angiogram. The Georgia rule is that a hospital has a duty to exercise reasonable care to its patients only if the hospital knows, through its agents and servants, that there is a danger to the patient in the administration of the drug. The Court was unwilling to rule that the hospital had a duty to inform the patient of the dangers of the contrast medium Thorotrast when there was no evidence to show that either the hospital or its agents knew that this particular drug was used. Consequently, the plaintiff was unsuccessful in his action against the hospital.

The Importance of the *Allrid* Case

The *Allrid* case has a three-fold significance to those in the medical community. First, the Court, by upholding the validity of the medical malpractice exception to the statute of limitations, reaffirmed the constitutionality of the rights granted by the Georgia legislature to medical practitioners.

Second, the Court's ruling that the physician was not an agent of the hospital suggests a willingness on the part of the courts to view the relationship between the hospital and its staff physicians as one of employer-independent contractor, rather than employer-employee, as a matter of law, even where the parties do not clearly define the terms of their relationship in a written agreement. In the past, the courts were reluctant to make such a determination as a matter of law in the absence of a written agreement clearly defining the relationship between the hospital and the physician as one of employer-independent contractor.[6]

Finally, the *Allrid* case stands for the proposition that patients harmed by dangerous drugs taken many years before may be precluded, as a matter of law, from bringing a suit against the drug manufacturers, hospitals, or physicians, if the harm occurs more than 2 years after the drugs were administered. While this result may seem unfair, it may also be a necessary one in order to effectuate the intent of the Georgia legislature to eliminate belated, false, or frivolous medical malpractice claims.

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MAG Committees Are At Work

THERE ARE 52 regularly appointed MAG committees. As in the case of all large organizations, the accomplishments and productive activities of the Association are dependent upon the work done by these committees. Some meet on a regular basis, dealing with ongoing issues. Some function on a standby, "ad hoc" basis, becoming active as specific matters are referred to them.

There is concern that much that is accomplished by the committees goes unnoticed by the membership. To be able to follow progress in making meaningful recommendations, members must be informed about the issues being considered. For this reason, two things are being initiated this year: (1) MAG committees, in rotation, are being asked to report to the Executive Committee; and (2) regular updates of committee activities, as gleaned from these reports, will be included in each issue of the *Journal*.

It is hoped that MAG members will become increasingly aware of the work being done by the various groups. Then, when a physician has a problem or issue brought to his attention, he will be better able to refer it to the appropriate committee. Each year, physicians around the state are encouraged to relate to the Executive Committee interests which indicate where they might be assigned appropriately. Whenever possible, members are appointed to committees where they have expressed a willingness to serve.

Committees do good work when interested MAG members become involved. Make MAG more effective by following and participating in committee activities.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.

NEW MEMBERS

Alvarez, Rafael A., Baldwin—ACT—P
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Chao, Stephen C., Mitchell—ACT (N-2)—OBG
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Delgado, Mercedes L., Gwinnett-Forsyth—ACT (N-1)—GP
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Dixon, P. K., III, Hall—ACT (N-2)—GS
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Fodor, Frank, Bibb—ACT—P
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755 Monroe St., Macon 31201

Parikh, Bharat B., Laurens—ACT (N-2)—IM
VA Medical Center, Dublin 31021

Scott, James I., Georgia Medical—ACT (N-1)—GS
9-A Medical Arts Center, Savannah 31405

Wells, Perry B., Bibb—ACT (N-2)—OBG
770 Pine St., Suite 360, Macon 31201

Zegarra, Alex A., Southeast Georgia—ACT—GP
P.O. Box 1092, Vidalia 30474

PERSONALS

First District

Murray C. Arkin, M.D., of Savannah, was elected to Fellowship in the American College of Physicians. Dr. Arkin practices internal medicine and clinical immunology.

Savannah physician, **William A. Miller, M.D.,** was elected to Fellowship in the American College of Radiology in honor of his special contributions to the medical profession.

Second District

Robley D. Smith, M.D., of Tifton, completed the 150 hours of accredited CME requirements to retain active membership in the American Academy of Family Physicians.

George Yih-Liang Tseng, M.D., recently opened a pediatric practice in Conyers. He had practiced in Albany for 6 years previously.

Fourth District

John A. Harrell, Jr., M.D., Medical Director, DeKalb General Hospital, was recently honored by the American College of Physician Executives for his high achievements in both the practice of medicine and the management of health care organizations. Dr. Harrell is among the first physicians in the country to be awarded membership in the American College of Physician Executives and to be recognized for excellence in medical management.

Fifth District

MAG members recently elected as medical staff officers and department chiefs for 1982 at West Paces Ferry Hospital in Atlanta are: **S. Boyd Eaton, M.D.,** Chief of Staff; **James D. Kiley, M.D.,** Chief of Staff-elect; **Judson G. Black, M.D.,** Chief, Department of Medicine, and **G. Lester Forbes, Jr., M.D.,** Chief, Department of Pathology.

Oliver A. Sorsdahl, M.D., of Atlanta, was elected to Fellowship in the American College of Radiology.

Nanette K. Wenger, M.D., Professor of Medicine (Cardiology) at the Emory University School of Medicine, was a speaker at the IX World Congress of Cardiology in Moscow, Russia, June 20-26. Her symposium presentation was "Rehabilitation of Cardiac Patients: Long-term Results and Economic Significance." Her additional presentations were "Is Strenuous Physical Activity Appropriate for Coronary Patients?" and "Physician Practice: Management of Patients with Myocardial Infarction in the USA."

Tenth District

Jonathan S. Krauss, M.D., of Augusta, was elected to Fellowship in the American College of Physicians. Dr. Krauss is an assistant professor, Department of Pathology, Medical College of Georgia, and director of the Hematology-Hemostasis Laboratory at Eugene Talmadge Memorial Hospital.

SOCIETIES

The Medical Association of Atlanta, in cooperation with the MAG, is sponsoring a Far East Adventure. Departing October 3, 1982, and returning October 17, this exciting 15-day trip to the Orient includes visits to Tokyo, Kyoto, Singapore, and Hong Kong. Call Eleanor Somerville, MAA office, 881-1714, for further details and information.

DEATHS

Clarence H. Harper

Clarence H. Harper, M.D., died June 5 of a heart attack while on a fishing trip in the Gulf of Mexico. He was 55 years old. Dr. Harper had been a general practitioner and surgeon in Hilliard and Folkston for 22 years. He received his medical degree from Emory University and interned at Cook County General Hospital in Chicago. Dr. Harper was a member of the American Medical Association and the Medical Association of Georgia. He served in the Navy in World War II.

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MAG Policy Statement on
Hospital Staff Privileges for Limited Licensed Practitioners

The MAG Executive Committee considered the possibility of developing standards for use as criteria for granting hospital privileges to limited licensed practitioners. The Executive Committee also reviewed the past and current policies of the AMA House of Delegates and Board of Trustees with respect to the issue of hospital privileges for individual limited licensed practitioners. In summary, the Executive Committee believes that it is neither practicable nor legally appropriate for MAG to attempt to develop standards to be used as criteria for granting hospital privileges to any limited licensed practitioner.

Accordingly, the Executive Committee hereby adopts a position similar to the present policy of the American Medical Association: MAG recognizes the right of qualified limited practitioners to seek opportunities to utilize their knowledge and skills in hospital and other health care facilities. The evaluation of an applicant's credentials should be carried out under the same procedures used for all applicants for hospital or medical staff privileges. Operating room observation, record review, tissue review and medical care evaluation studies remain the foundation of evaluation for practice privileges for physicians and other independent practitioners providing professional services in hospitals. The evaluation of professional competency and performance should be initiated by the department in which privileges are granted, with recommendations as to the scope of privileges forwarded to the credentials and other appropriate committees in accordance with the hospital medical staff bylaws.

While recognizing the right of limited practitioners to seek hospital and other privileges as described above, the Executive Committee simultaneously reaffirms MAG's policy (adopted by the 1980 MAG House of Delegates) recognizing, among other things, "that no professional license confers a constitutional right to practice that profession in a hospital. The MAG supports the right of the hospital to deny staff privileges to a class of limited health care practitioners who are licensed by the state, so long as such exclusion has a rational basis and is reasonably related to the operation of the hospital."

(Adopted March 11, 1982, by MAG Executive Committee. Ratified April 22, 1982, by MAG Board of Directors.)

Committee Activities . . .

(At the June 6 MAG Executive Committee meeting, the chairmen of three MAG committees reported on the current and future activities of their committees. Presented below are summaries of those reports.)

Committee on Physician's Assistants

In the past year, the PA Committee has been chiefly involved in working with the Composite State Board of Medical Examiners to revise its rules for physician's assistants. This year we intend to address two main issues. First involves the credentialing of PAs by hospitals; we intend to find out how many Georgia hospitals extend privileges to PAs and what bylaw provisions permit these privileges.

Our second task is to work with the Composite Board, directors of the state's PA training programs, and the National Commission for the Certification of PAs in order to devise a test for all PAs who wish to be certified by the Composite Board. Currently, there exists a national test for primary or "type A" PAs, but the Composite Board does not require it for certification. No test for the various specialty "type B" PAs has yet been devised which would also be suitable for "type A" PAs. We hope this fall to begin discussions on these points and to work toward their resolution.

Richard W. Cohen, M.D.
Chairman

Committee on Education

The MAG Education Committee conducts its work through four subcommittees which meet before each of the Committee's three annual meetings.

Our *Accreditation Subcommittee* is responsible for site-surveys of hospitals and state specialty societies to evaluate and accredit programs of continuing medical education (CME). Presently, some 33 hospitals and societies are accredited for CME by the MAG.

The *Hospital CME Subcommittee* encourages the development of medical education programs in hospitals not yet accredited. In consultative visits around the state, our members offer their expertise. Occasionally the MAG has also authorized Category 1 CME credits for worthwhile programs in unaccredited hospitals.

Our *Medical Schools Subcommittee* has as its chief task the liaison with Emory, Medical College of Georgia, Morehouse, and Mercer. Since 1965, the Subcommittee has, for example, coordinated a biennial conference which draws the deans and faculty from the various schools together with physicians in private practice to discuss important issues.

Finally, addressing the question of teaching the public about health is the *Subcommittee on Health Education*. Our efforts to date have largely addressed the issue of health education in the public schools; we have recently endorsed a plan to upgrade the state's health education curriculum and to improve the training of those teachers charged with leading health classes.

Victor A. Moore, M.D.
Chairman

Occupational Health Committee

Dr. Charles Hollis has selected public health education as a top priority for the Medical Association of Georgia for 1982-83. Workers throughout the state are prime candidates for such health education. Some companies have part-time or full-time physicians in charge of medical departments whereas others use the services of occupational health nurses for a variety of occupational medical programs, including health promotion and education. The majority of our state's workers, however, are employed by businesses that have no medical professional personnel.

The private practicing physicians of Georgia are in a position to offer their services and expertise to all companies, and to their employees and families. Existing health educational material can be recommended or furnished or original articles prepared. Doctors can volunteer their services as speakers before employee groups on a wide variety of health matters. Companies frequently conduct disease detection programs for hypertension, diabetes, glaucoma, etc., and physicians can provide a valuable service by volunteering to participate in these programs. Companies frequently call for assistance to teach cardiopulmonary resuscitation, first aid, etc.

Our Occupational Health Committee plans to work closely with the Education Committee under the direction of Dr. Victor Moore in coordinating these efforts. Local medical associations can also offer the services of a Health Education Committee or Speakers' Bureau to assist companies with health education programs.

Robert P. Cunningham, M.D.
Chairman

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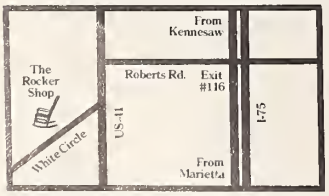
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"Highlights"
Executive Committee Meeting of July 11, 1982

In its meeting of July 11, the MAG Executive Committee approved the plans for the Risk Management Committee to develop curricula for four new risk management seminars:

1) a 1 to 2-hour program designed specifically for hospital staff;
2) a ½ to 1-day Risk Management Program for office personnel and perhaps for hospital personnel as well;
3) a 2-day program specifically suited to various medical specialty groups;
4) a refresher course for those physicians who have received their full 3-year premium discounts.

The Executive Committee also called for creation of a steering Committee to develop a "section on hospital medical staffs" to the MAG House of Delegates. The section would address problems currently being faced by hospital medical staffs. The AMA is presently at work developing this section for its House; H. Hilt Hammett, Jr., M.D., is serving on the AMA steering committee.

Plans are also set for an MAG State Leadership Conference, to be held this November 12-14 at Callaway Gardens. Intended for leaders of county medical and state specialty societies, MAG officers, committee chairmen, and auxiliary members, the conference will feature prominent speakers on hospital medical staff problems, the FTC, peer review, and other important issues. Ample time will be given for participants to exchange their views in discussion groups.

Finally, the Executive Committee voted that the MAG arrange with MAG Mutual Insurance Company to assist physicians entering practice in the purchase of Surplus Certificates for MAG Mutual professional liability insurance. Specifically, MAG would receive from MAG Mutual Surplus Certificates of $1500 each in lieu of repayment by MAG Mutual of its debt to MAG. MAG would then sell the Certificates to young doctors who could pay back the Association over several years.

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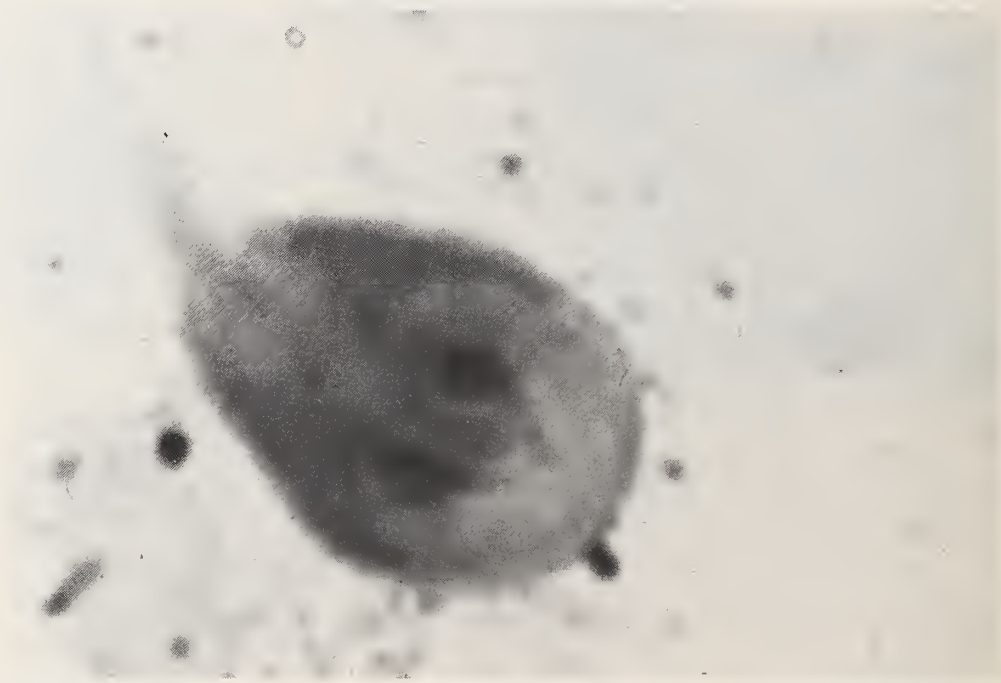
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include Giardia lamblia (motile trophozoites), Strongyloides stercoralis (larvae and/or eggs in advanced stages of development), Clonorchis sinensis (eggs), Fasciola hepatica (eggs), Trichostrongylus orientalis (eggs), and Isospora (coccidia).

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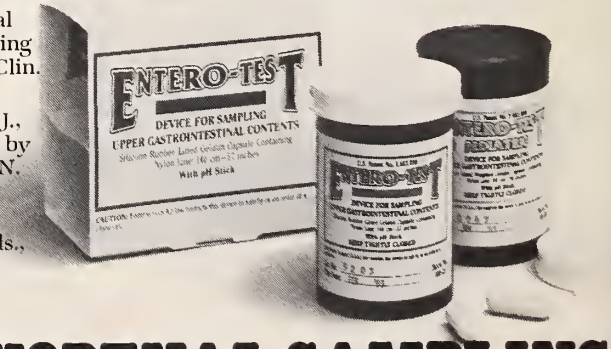
Giardia lamblia

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976:294:687-90.

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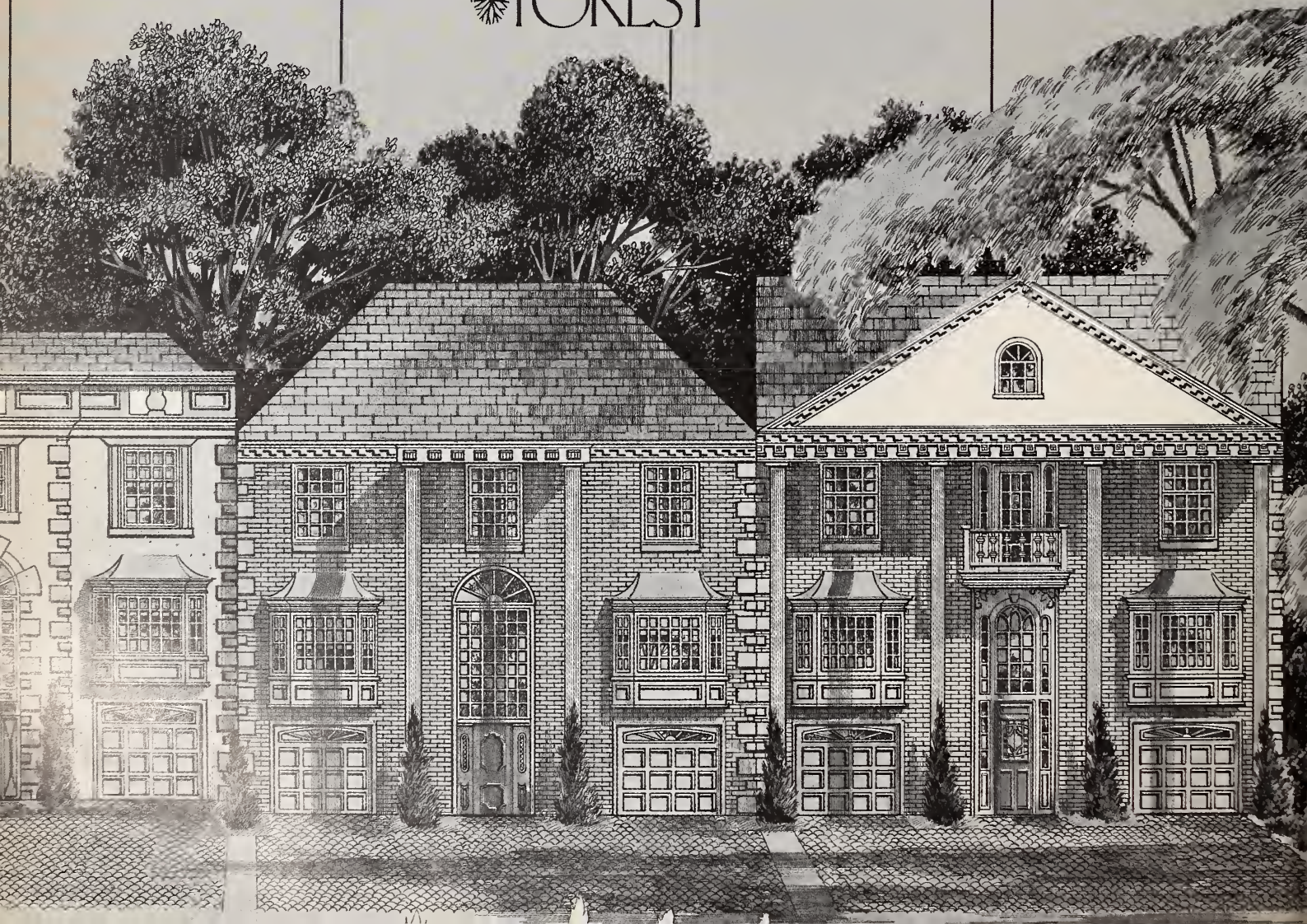
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THE COVER

Atlanta is the site of the upcoming SMA-MAG Scientific Assembly. The preliminary program is featured in this issue.

Cover design by Jill Harris Brown of Atlanta.

Incidental Intelligence . . .

Eye Bank Honors Medical Association of Georgia



William D. Logan, M.D. (right), accepts an award on behalf of the MAG from Louis A. Wilson, M.D., Director of the Georgia Lions Eye Bank.

The Georgia Lions Eye Bank recently recognized the Medical Association of Georgia for its support for organ donation. Presenting the award was Louis A. Wilson, M.D., Eye Bank Medical Director, to William D. Logan, M.D., Secretary of the Medical Association of Georgia.

The *Journal* has featured articles on eye and kidney donation, and through the sponsorship of the MAG, television spots about organ donation were produced.

The Georgia Lions Eye Bank provides donor eye tissue for corneal transplants and research. A total of 825 transplants were made possible through the Bank last year.

"The contributions of the Medical Association of Georgia to professional and public education have been of tremendous value in restoring sight to those in need," stated Dr. Wilson.

Aspirin and Reye Syndrome: A Warning

Reye syndrome typically occurs during recovery from viral infections, particularly influenza and chickenpox. The incidence of Reye syndrome is < 1/100,000 in the population < 18 years of age, and the case-fatality rate is 20-40%.[1] Although the etiology of Reye syndrome is unknown, several epidemiologic studies have demonstrated an association between Reye syndrome and salicylate use.[1] These studies do not establish causality, and their interpretation has been contested by industry representatives. Nonetheless, the strength of the suggested association was sufficient for the Surgeon General to advise against the use of aspirin in children with chickenpox or influenza-like illness. This recommendation was based on an evaluation sponsored by the Food and Drug Administration, the Centers for Disease Control (CDC), and the National Institutes of Health.[2] In addition, the American Academy of Pediatrics Committee on Infectious Diseases conducted an independent review and issued a similar warning.[3]

Children with certain chronic diseases, such as juvenile rheumatoid arthritis, require daily aspirin therapy. CDC currently advises that such therapy be continued because the benefits of aspirin in these children greatly outweigh the risks. Studies to determine the incidence of Reye syndrome in this special group are being planned.[4] *(Reported by the DHR Office of Epidemiology.)*

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3. Committee on Infectious Diseases. Aspirin and Reye syndrome. Pediatrics 1982;69:810-12.
4. Rogers MF. Viral Diseases Division, Center for Infectious Diseases, CDC. Personal communication.

Rocky Mountain Spotted Fever in 1982 — An Update

The first patient with Rocky Mountain spotted fever (RMSF) this year had onset of symptoms on April 14. Since then, 24 cases of RMSF have been reported to date (7/15/82) to the Office of Epidemiology at the Georgia Department of Human Resources (DHR). Two of these cases resulted in death: one in an 11-year-old girl from Clayton County, the other in a 67-year-old woman from Fulton County. Patients with RMSF ranged in age from 3-67 years (median age = 10 years); 19 (79%) were white; 22 (92%) gave a history of tick attachment or contact with a tick-infested area; and 20 (83%) were residents of counties north of Macon. Fifteen cases were serologically confirmed either by an indirect fluorescent antibody (IFA) titer of $\geq 1:128$ or by a four-fold titer rise. The IFA test is more sensitive than the previously available complement fixation test and can be requested through the Virology Laboratory, DHR.

Because RMSF may imitate a number of rash illnesses, physicians are urged to submit paired (or convalescent) sera for IFA testing to confirm the diagnosis. When RMSF is suspected, however, treatment should not be delayed while awaiting laboratory results. Physicians and hospitals are requested to notify promptly local health departments of all RMSF cases.

(Reported by the DHR Office of Epidemiology.)

Vice President Bush Speaks at Morehouse School of Medicine

(Editor's note: On July 21, 1982, Vice President George Bush flew to Atlanta for the express purpose of participating in the dedication ceremonies of Morehouse School of Medicine's new Basic Medical Science Building. Dr. Charles Hollis, Jr., was one of the honored guests seated on the speaker's platform with the Vice President. Presented below are excerpts of Mr. Bush's remarks on that day when the first and only predominantly black medical school to be established in the United States in the 20th Century dedicated its new building.)

I am very pleased to be here today with many outstanding educators — wonderful men and women who have dedicated themselves to helping people from all walks of life, people of all colors and political persuasion and especially our nation's poor.

I feel most comfortable and at home here. Certainly, I don't feel like William Allen White did in 1928. White was attending a Democratic convention as a reporter. Senator James Reed was scheduled to open the proceedings. As he stood at the rostrum, Reed looked around and found there were no ministers present to open the proceedings with a prayer, but he did notice White, a Republican, seated in the press gallery. So he said,

"Gentlemen, since there are no ministers present, I shall call on my good friend, William Allen White, to open the convention with prayer."

White, boiling mad, strode to the podium and said,

"Ladies and gentlemen, you will have to excuse me. You see, I am a little out of my element, and the fact is, I prefer the Lord does not know that I am here."

Well, ladies and gentlemen, I feel very much in my element here, and I am very glad that the Lord does know I am here.

I not only want the Lord to know, but the American people to know how important it is that we have gathered to dedicate the New Basic Medical Science Building of Morehouse School of Medicine. It is difficult for me to express my admiration and appreciation to you who have devoted your lives to the advancement of medicine in order that all men and women may lead healthier, longer, and more productive lives.

Morehouse School of Medicine is the first and only predominantly black medical school to be established in the United States in the 20th Century. This is not a particularly impressive record for our country; in fact it is a tragic record, considering the burdens of our needy in today's society. But no one can deny that the faculty and students of Morehouse are deserving of our praise and warrant our continued support for what they have done to advance the health care of our most needy citizens.

I read in your brochure that the mission of the Morehouse School of Medicine is "to train more minority students as primary care physicians by preparing them to appreciate the health needs of underserved populations and to understand the role of primary care physicians in meeting those needs." It is a simple declaration of purpose. It is also one that, in its subtlety, underscores all you have done and all strive to do.

In 1985, Morehouse School of Medicine will award its first, 4-year, medical degree. In order to assist in this endeavor, President Reagan, last September 15, reenforced his belief that Morehouse and other historically black colleges and universities must be treated uniquely.



Louis Sullivan, M.D., Dean of Morehouse School of Medicine, and Vice President George Bush at the dedication of the medical school's Basic Medical Science Building in July.

In an Executive Order, the President mandated that the Secretary of Education supervise the development of a federal program designed to achieve a significant increase in the participation by historically black colleges and universities in federally sponsored programs.

"This program seeks to identify, reduce, and eliminate barriers which may have unfairly resulted in reduced participation, and reduced benefits from, federally sponsored programs." The President added that, "This program will also seek to involve private sector institutions in strengthening historically black colleges."

It is in this spirit that Morehouse School of Medicine will receive $2.6 million from the Department of Education.

The President has also taken action to save Meharry Medical College in Nashville, Tennessee from closing. We are absolutely determined that this prestigious institution, founded more than 100 years ago, which has educated more than 40 percent of all black physicians in the United States, will survive and maintain its stature as one of the great schools of medicine in this country.

To the students of this and other institutions, we must, as Mary McLeod Bethune wrote, leave, "a responsibility to our young people." It was in her Last Will and Testament in which she said,

"The world around us really belongs to youth, for youth will take over its future management. Our brethren must never lose their zeal for building a better world. They must not be discouraged from aspiring toward greatness, for they are to be the leaders of tomorrow. Nor must they forget that the masses of our people are still underprivileged, ill-housed, impoverished and victimized by discrimination. We have a powerful potential in our youth and we must have the courage to change old ideas and practices so that we may direct the power toward good ends."

It will be through education that new opportunities for our nation's less fortunate will be provided. It will be through education that justice is furthered and bigotry scorched from the consciousness of people and by which true equality no longer is a dream but a reality.

Congratulations to Dr. [Louis] Sullivan [Dean of Morehouse School of Medicine], the faculty, and the students of Morehouse. This is a great day for all of you. It is an honor for me to be part of this ceremony which commences a new era for this great institution.

MAG Meets with Deans

On July 21, in a meeting preliminary to the formation of an MAG Dean's Committee, Charles D. Hollis, Jr., M.D., met with the deans of three of Georgia's medical schools: James F. Glenn, M.D., from Emory, Louis Sullivan, M.D., from Morehouse, and Fairfield Goodale, M.D., from MCG. The purpose of the meeting was to increase effective communication between MAG and the schools. Matters of mutual concern were discussed and included the following:

1. It would serve a useful purpose for the deans and the MAG President to meet once each quarter.
2. It was mutually agreed that it would be advantageous for the deans to regularly attend Executive Committee meetings.
3. Public education should be the priority project. The deans agreed to make available their facilities for developing television video tapes and radio spots announcements for the public and offered help in developing materials for these spots. They would be distributed by the MAG.
4. The deans agreed to have an editorial committee of medical school faculty provide public education articles on a regular basis, applicable to the season and to matters of urgent importance as far as public health is concerned. MAG would be responsible for distribution.
5. Urgent need was recognized for representatives of the MAG and the medical schools to meet with legislators prior to each legislative session in order to give them constructive input regarding medical matters.
6. The importance of business-medicine coalitions and cost containment efforts was acknowledged. The medical schools could participate in meaningful discussions with the business community regarding aspects of limiting costs.
7. The deans requested more frequent visits by MAG officers to the medical schools.
8. The AMA's student section was applauded as a meaningful, rewarding experience for both the students and organized medicine.
9. The question was raised regarding studies in which more humane care for the elderly could be accomplished, while also limiting available health care funds for this single group.
10. In certain states, notably Alabama, the medical centers have developed a statewide telephone consulting service to assist physicians in outlying areas. Such a system could be of value to Georgia physicians, and the schools agreed to work toward developing a similar one.
11. To help alleviate the geographical maldistribution of physicians, the medical schools should consider ways to involve community hospitals more extensively in training programs for both students and house staff.
12. Since matters considered by organized medicine are of mutual interest and concern to both the state medical association and to the medical schools, ways will be considered to involve more medical school faculty members in MAG committee activities.

This meeting was very constructive, and directions were set for more effective, continuing involvement of the medical schools in the Association's activities. Specific plans are being made to implement some of the above matters. It was encouraging to see the enthusiasm of both groups as they considered the potential of expanding the involvement of their resources.

Physicians' Pension Plans Threatened by Proposed Restrictions

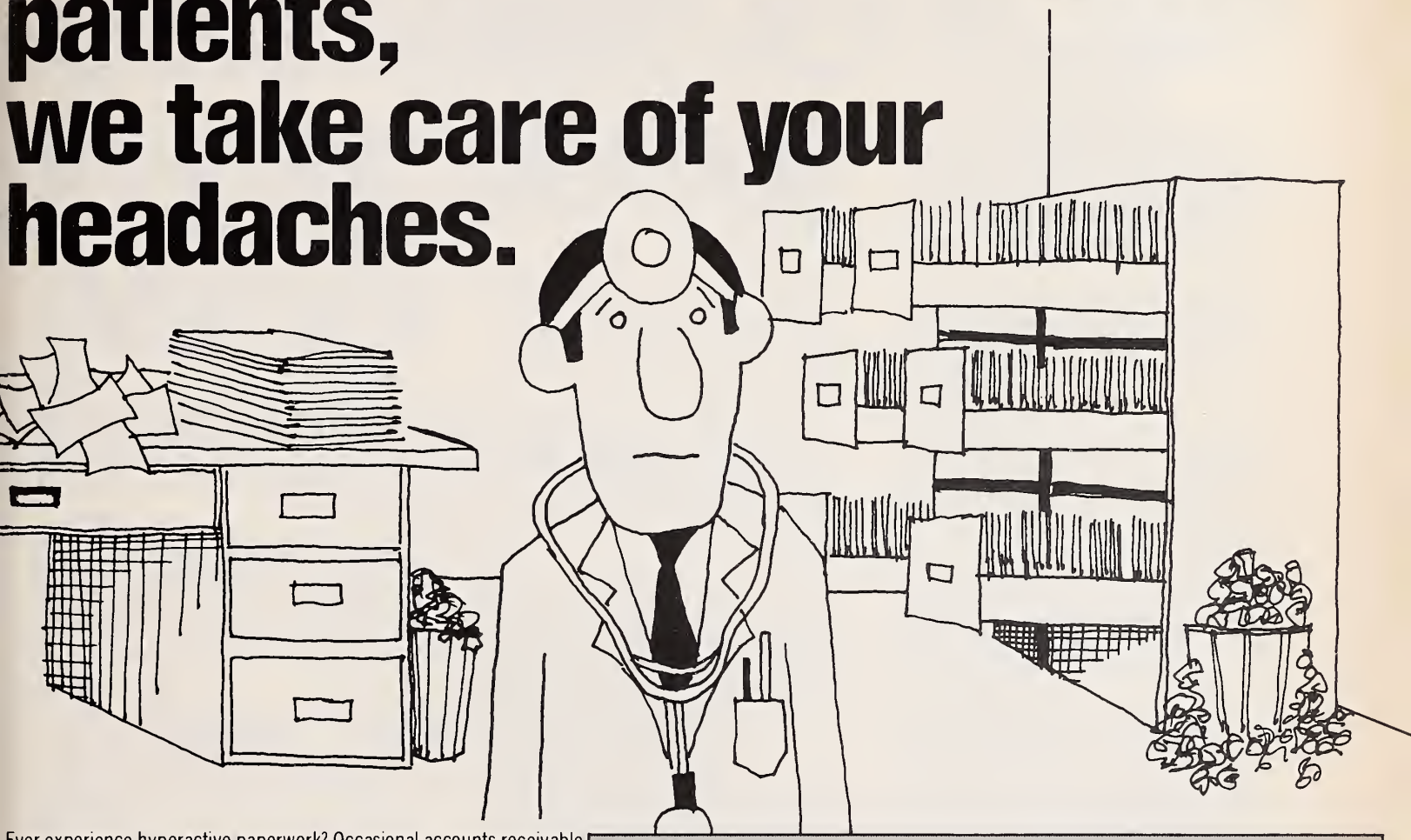
The Medical Association in Georgia has been in communication with the AMA, our US Representatives, and our US Senators since May 27 regarding HR 6410 currently pending before Congress. HR 6410, the Pension Equity Tax Bill of 1982, if passed, would single out professional corporations for restrictive treatment and attack your private pension system and/or the pension benefits of professional corporations. HR 6410 affects the reimbursement plans, disability insurance, group term life insurance, etc., of professional corporations by:

1) Placing Keogh contribution limits and other restrictions on the qualified plan of professional corporations.
2) Eliminating the deduction for *all* other fringe benefits for the professional employee.

Obviously this is an effort to raise additional revenues and the timing in Washington is ripe for this type action. Although MAG has been in contact with our Congressmen since May on this issue, *NOW* is the time for you to register your objection to HR 6410 by writing your and/or all of Georgia's Congressmen and US Senators urging defeat of HR 6410. Please draft your own message, but essentially state:

> I want to express my strong opposition to HR 6410 (the Pension Equity Bill of 1982). If this bill passes, it will significantly destroy the benefits which are provided by my corporation for all of its employees and will substantially weaken our ability to save for retirement. I urge you to strongly oppose this destructive bill which will virtually eliminate benefits for me and my employees and thousands of others like me.

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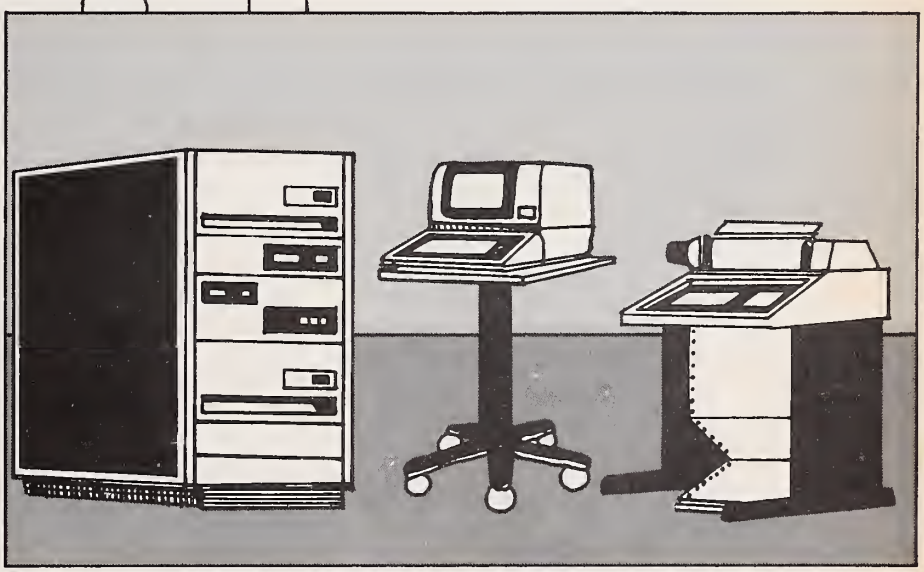
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MEDICAL MEETING CALENDAR

SEPTEMBER

24—*Savannah:* **Clinical Diabetes in 1982.** AMA Category 1 and AAFP prescribed credits. Contact Kaveh Ehsanipoor, MD, Memorial Med. Ctr., P.O. Box 23089, Savannah 31403. PH:912/356-8595.

24-25—*Unicoi:* **Georgia Rheumatism Society — Annual Meeting.** Category 1 credit. Contact Bill Stokes, Exec. Dir., Arthritis Found., 2799 Delk Rd., SE, Marietta 30067. PH:404/952-4254.

24-26—*New Orleans, LA:* **Southern Medical Association Regional Postgraduate Meeting.** Category 1 credit. Contact Jeanette Stone, SMA, P.O. Box 2446, Birmingham, AL 35201. PH:205/323-4400.

25—*Rome:* **Diabetes Mellitus 1982.** AMA Category 1 and AAFP prescribed credits. Contact John H. McFarland, MD, Floyd Cty. Med. Ctr., 302 Turner McCall Blvd., Rome 30161. PH:404/291-2075.

26-30—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

27-29—*Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

30-Oct. 1—*Macon:* **Second Annual Symposium: Diabetes Mellitus.** AMA Category 1 and AAFP prescribed credits. Contact Office of Med. Ed., Med. Ctr. of Central Ga., 777 Hemlock St., Macon 31201. PH:912/744-1114.

30-Oct. 2—*Savannah:* **Southeastern Allergy Assn.** Contact G. Frederick Hieber, MD, 1401 Monticello Blvd., North, St. Petersburg, FL 33703. PH:813/525-0861.

OCTOBER

4-5—*Atlanta:* **Contraception: Yesterday, Today, and Tomorrow.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

6-7—*Atlanta:* **Ga. Chapter, American Academy of Pediatrics — Fall Meeting.** Category 1 credit. Contact William Mankin, Exec. Secy., 4059 Land O'Lakes Dr., NE, Atlanta 30342. PH:404/237-3922.

7-9—*Hilton Head Island, SC:* **Fourth Annual Frontiers in Nutrition.** Category 1 credit. Contact Jane Greene, Ga. Inst. of Human Nutrition, BD 101, MCG, Augusta 30912. PH:404/828-4861.

14-15—*Atlanta:* **Use and Abuse of Antibiotics — Old and New.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Atlanta:* **The Basic Course on Pain: Diagnosis and Management of Chronic Pain.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-17—*Sea Island:* **Georgia Orthopaedic Society — Annual Meeting.** Category 1 credit. Contact James Averett, Jr., MD, 105 Collier Rd., NW, Ste. 2010, Atlanta 30367. PH:404/355-1798.

15-16—*Atlanta:* **ECG Interpretation & Arrhythmia Management.** Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

21-22—*Atlanta:* **Cardiology for the Emergency Department Physician.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-22—*Macon:* **Georgia Rural Health Conference.** Contact J. Stephen Wright, PhD, Ofc. of Rural Health, Ga. Southern College, Statesboro 30460. PH:912/681-5144.

21-23—*Atlanta:* **33rd Annual Meeting, Association of American Physicians and Surgeons: Competition in Medicine — Good or Bad News?** Contact Daniel Jordan, MD, 35 Collier Rd., NW, Ste. 385, Atlanta 30367.

25-27—*Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

29—*Macon:* **Rheumatology 1982.** Category 1 credit. Contact John Hudson, MD, Med. Ctr. of Central Ga., 784 Spring St., Macon 31201. PH:912/744-1562.

29-30—*Atlanta:* **Chest Radiology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

30-Nov. 2—*Atlanta:* **SMA-MAG Scientific Assembly.** AMA, AAFP, ACEP, and ACOG credits. Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800-282-0224 (toll free in Ga.)

NOVEMBER

11-13—*Atlanta:* **34th Annual Meeting, Ga. Academy of Family Physicians.** Category 1 and AAFP prescribed credits. Contact Camille Day, 11 Corporate Sq., Ste. 205, Atlanta 30329. PH:404/321-7445.

12-14—*Callaway Gardens:* **MAG Leadership Conference.** Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in Ga.).

DECEMBER

3-4—*Atlanta:* **Clinical Management of Coronary Disease and Dual-Mode Exercise Testing.** Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

9-10—*Atlanta:* **MKSAP VI Review Course.** Contact Registrar, College of Physicians, 4200 Pine St., Philadelphia, PA 19104. PH:800/523-1546.

17-18—*Atlanta:* **Panic Disorders.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

The Journal *is interested in receiving information on continuing education meetings in Georgia. Please mail such information* 2 months in advance *of the issue in which you wish it to appear to: Stephen Davis, Director of Education, MAG, 938 Peachtree St., NE, Atlanta 30309.*

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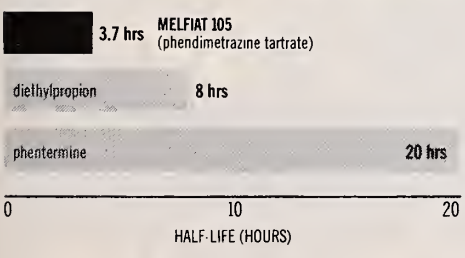


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References: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine,* unclassified document ADAMHA, HHS. Office of Medical and Professional Affairs, NIDA, 1980.
2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

MELFIAT® 105 UNICELLES® ℂ III
(phendimetrazine tartrate) Sustained-Release Capsules 105 mg

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INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.
Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
Allergic: Urticaria.
Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 μg/ml and 0.09 μg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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Rebirth of an Old Technique — The Use of Clean, Intermittent Self-Catheterization

CHARLES R. GERSHON, M.D., *Atlanta**

As sometimes occurs in medicine and history, a commonplace custom of the past is rejuvenated in the present and given such accolades as "daring" and "ingenious." One such relic from the past is the use of clean, intermittent self-catheterization.

It is well known that the old Irish sea captains, apparently plagued with obstructive uropathy, would carry a catheter in their caps to obtain relief from their malady. It is not as well documented, but certainly postulated, that Benjamin Franklin wove himself a catheter so as to relieve the obstruction caused by his bladder calculus. A well-heeled Frenchman of the 19th Century would not have considered leaving his Paris home in inclement weather without his umbrella, smartly equipped with a screw-off top, within which was a catheter.

Possibly the advent of sophisticated microbiology and the apparent need for asepsis led to a decline in the use of clean, intermittent self-catheterization. This decline persisted until the early 1970s.

Theory Behind the Technique

Most authorities agree that lower urinary tract infections occur primarily from retrograde contamination into the bladder. Over 20 years ago, Hinman[1] observed that when *Escherichia coli* were inoculated into a healthy bladder, no infection occurred. How does one obtain and/or maintain a healthy bladder? Lapides[2] has long advocated frequent voiding, on the basis that increased intravesical pressure destroys the tissue integrity or blood supply of the bladder. Parsons and associates[3] gave credence to this concept by demonstrating that bladder mucin plays a significant role in the primary antibacterial defense of the bladder. Data have shown that destruction of bladder mucin is associated with increased microbial attachment to the bladder. In recent experiments, Perlow and associates[4] demonstrated that vesical overdistention disrupts the mucin layer of the bladder. Thus, theoretically, if one preserves both the blood supply and mucin layer of the bladder, the bladder qualifies as healthy and infection can be resisted — even in the presence of bacteria. Therefore, if one catheterizes frequently enough to prevent overdistention, infection can be prevented.

It must be stressed that this is a clean, not a sterile, technique. The patient can, in fact, use the same catheter repeatedly, washing it off with soap and water after each use. The catheter does not have to be kept in a sterilizing solution between uses. In fact, it can be most conveniently kept in the patient's front pocket or purse. No gloves and usually no antibacterials are necessary.

Use in Neurogenic Bladder

Over the past 3 decades, the urological management of the patient with a spinal cord injury has been the subject of much discussion. Most authors have implicated renal failure as the most common cause of death, in the long term, for this group of patients.[5] A recently reported 15-year follow-up study on Viet Nam veterans, however, showed their renal death rate to be one half that of World War II and Korean veterans.[6] Much of this improvement is due to not

* Dr. Gershon practices urology and male infertility. Send reprint requests to him at 340 Boulevard, NE, Suite 618, Atlanta, GA 30312.

having an indwelling catheter. Even quadraplegics with minimal hand function can catheterize themselves every 3 to 4 hours and remain dry and uninfected. Most of these paralyzed patients will require anticholinergics to remain dry; this has to be determined urodynamically.

One of the greatest uses for intermittent self-catheterization (ISC) has been in myelodysplastic children. One traditional method of treatment in these children was diversion. Now, many who were diverted secondary to persistent incontinence can remain dry with appropriate drug therapy and ISC.[7] In fact, many of these children now are undergoing so-called "undiversion," or reconstitution of their urinary tract, and are then being placed on ISC postoperatively. ISC is certainly more socially acceptable and frought with fewer long-term consequences than diversion.

Use in Bladder Decompensation or Retention

But what about the patient whose problem is not incontinence but retention? The woman who goes into retention after a Marshal Marchetti Krantz operation or the elderly who goes into retention after a major operation would both benefit greatly with ISC. In these cases, the object is to increase the myogenic tone and decrease vesical overdistention and thus, rehabilitate the bladder. This technique can be particularly helpful as shown in the following case.

Case #1: WA was a 79-year-old man who went into retention after repair of a ruptured abdominal aortic aneurysm. He had been quite ill for a long time. Multiple attempts at removing the indwelling catheter and initiating spontaneous voiding were unsuccessful. Because of his aortic graft and his somewhat debilitated postoperative condition, it was felt that endoscopy and possible prostatectomy would be somewhat precarious. He was thus taught ISC and was able to leave the hospital without an indwelling catheter and without the risk of another operation at such an early time postoperatively. Eventually, after his graft had time to heal, he could be brought back in for an elective prostatectomy.

In both rehabilitation of the bladder and prevention of infection, keeping intravesical pressure low by preventing overdistention is of primary importance.

Acceptance of Technique

Possibly the most difficult aspect regarding ISC is its acceptance by patients, doctors, and the nursing staff. After all, how does one catheterize oneself with the same catheter, using no gloves and no antiseptic prep, and not get into trouble with a urinary tract infection?

In both rehabilitation of the bladder and prevention of infection, keeping intravesical pressure low by preventing overdistention is of primary importance.

Lapides[8] found that 65% of his patients who were doing clean ISCs had completely normal urine. Of the 35% who had persistent bacteriuria, the vast majority, when questioned closely, had not been cathing as frequently as necessary.

Case #2: AH was an 81-year-old man who underwent a colon resection for adenocarcinoma. Postoperatively, he went into retention. He was then begun on a bladder rehabilitation program consisting of ISC every 3 to 4 hours, maintaining a volume of 300 cc. or less. He did quite nicely with this for 4 or 5 days. However, 1 day he slept 12 hours and did not catheterize himself. Within the next 12 hours, he had an oral temperature of 101° F. He was started on antimicrobial therapy and proper catheterization technique, and his temperature came down immediately. Many of the problems associated with ISC stem either from such an improper technique or from an improper use of the technique.

Thus, intermittent, clean self-catheterization can be used to rehabilitate the bladder in lieu of chronic indwelling urethral or suprapubic catheters, with their attendant problems such as urethritis, stones, and infection.

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Chronic oral and perineal candidiasis can be a clue to immunologic dysfunction, especially if associated with diarrhea, failure to thrive, and/or rhinorrhea.

Defects in Cell-Mediated Immunity

MARGARET F. GUILL, M.D., *Augusta**

EVALUATION OF THE cell-mediated immune system beyond the screening stage of delayed hypersensitivity skin tests most often requires the laboratories of a research center because the parameters used are still highly specialized. Patients suspected of having primary T-cell deficiency are most often children with recurrent viral and/or bacterial infections associated with chronic diarrhea and failure to thrive. As in all diseases, there is a spectrum of severity, and thymic function may be partially or entirely deficient. As more sophisticated techniques of evaluation are developed, more subtle defects will be diagnosed (Table 1).

TABLE 1 — Evaluation of Cellular Immune Function

In vivo	
	Delayed hypersensitivity skin tests
	Challenge with neo-antigens
In vitro	
	Enumeration of T-cells — E-rosettes
	Mitogen and antigen stimulation of proliferation
	Mixed lymphocyte culture

DiGeorge Syndrome

The DiGeorge Syndrome of dysmorphic facies, thymic hypoplasia, aortic arch malformations, and primary hypoparathyroidism is the classic disease of cell-mediated immunodeficiency.[1] Failure of embryonic development of the third and fourth pharyngeal pouches underlies the spectrum of associated abnormalities. The primary presentation is usually neonatal tetany requiring calcium supplementation. The cardiac malformations can cause significant distress in the newborn. Chronic oral and perineal candidiasis can be a clue to immunologic dysfunction, especially if associated with diarrhea, failure to thrive, and/or rhinorrhea. There is a propensity for unexplained sudden death in these children. They are also subject to overwhelming infection from the administration of live viral vaccines and to graft-versus-host disease from blood products containing viable lymphocytes. Treatment with corticosteroid containing drugs will suppress what little cell-mediated immune function they have and should be avoided. If not diagnosed in the newborn period by dysmorphic features, cardiac abnormalities, and hypocalcemia, they may present later in life with recurrent viral and fungal infection and are particularly susceptible to *Pneumocystis carinii* pneumonia.

Evaluation of thymic function involves enumeration of T-lymphocytes, possible because of their receptors for sheep red blood cells which cause rosette formation (E-rosettes) (Figure 1). Lymphocyte proliferation can be stimulated *in vitro* by both nonspecific mitogens and specific antigens. Comparison of stimulation to that of a normal control can give an estimate of function. Production of lymphokines, which are specific T-lymphocyte products, can also be quantitated. The mixed lymphocyte culture indicates the ability of a patient's lymphocytes to recognize genetically dissimilar lymphocytes as foreign and respond by proliferation. All of these parameters are deficient in patients with DiGeorge Syndrome.

Treatment consists of correction or palliation of the cardiac defect, parathormone replacement, and fetal thymus transplant. It is important that live viral vaccines be withheld from patients with a family history of immune defect or suspicion of cell-mediated dysfunction and that any blood products they receive be irradiated to eradicate any viable lymphocytes. Because of the autosomal recessive inheritance, genetic counselling is needed.

* Dr. Guill is Assistant Professor of Pediatrics and Medicine, Section of Allergy and Immunology, Medical College of Georgia, Augusta, GA 30912. Send reprint requests to her. This article was sponsored by the Allergy and Immunology Society of Georgia. It is the last in a series of four.

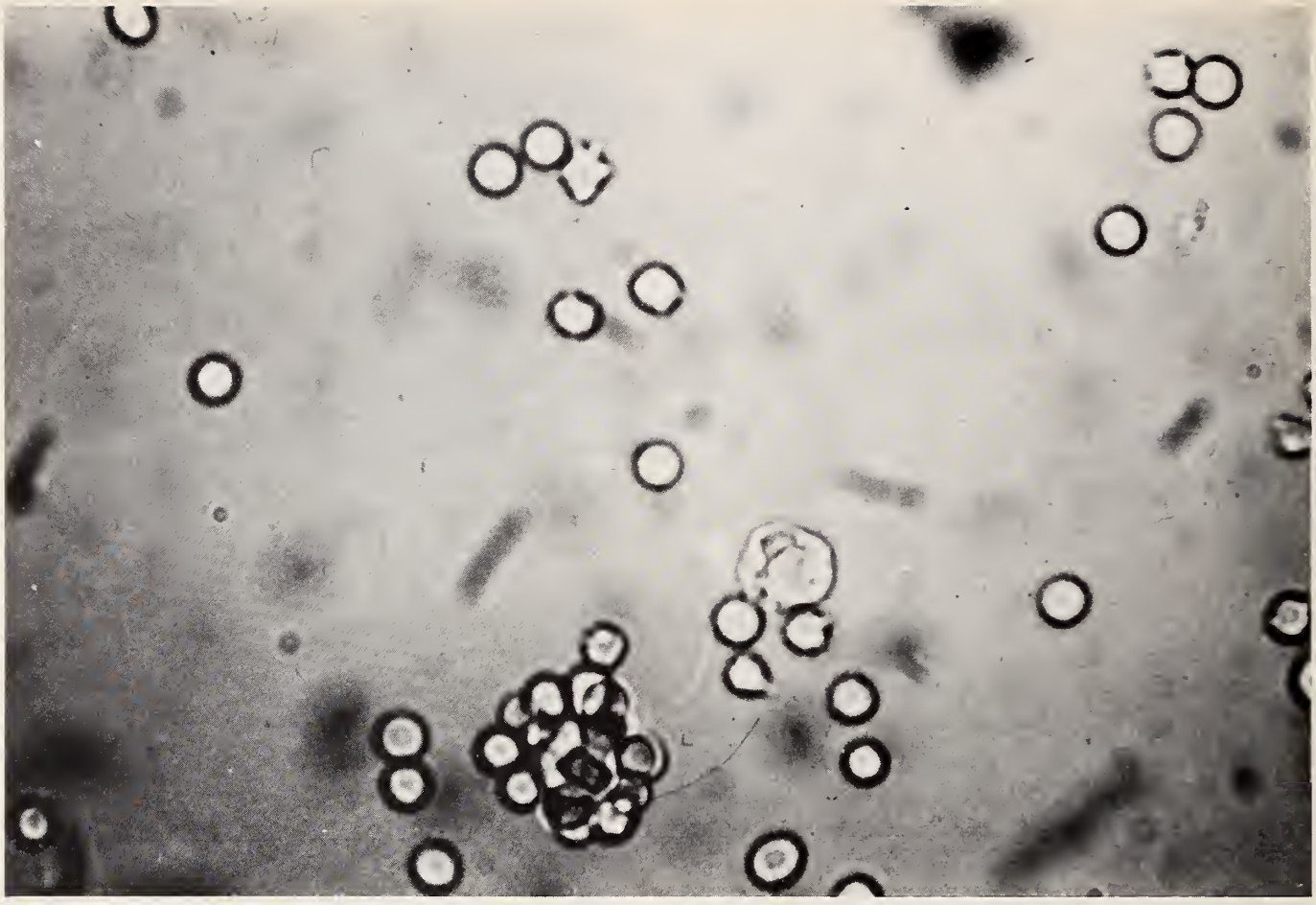


Figure 1 — T-Lymphocytes possess receptors for sheep red blood cells, causing spontaneous rosette formation when a suspension of lymphocytes is mixed with sheep erythrocytes. Normally, 60-70% of circulating lymphocytes are T-cells and will form rosettes.

A few patients with enzyme deficiencies in the purine salvage pathway and immunodeficiency have been described. Those with nucleoside phosphorylase deficiency have severe impairment of T-cell function.[2] Immunologic reconstitution has generally not been successful; transfusions of packed red cells for enzyme replacement have been beneficial in some.

Chronic Mucocutaneous Candidiasis

Partial deficiencies of T-cell function have also been identified. Chronic mucocutaneous candidiasis represents failure of T-cell response to candida, generally associated with intact response to other antigens. E-rosettes and non-specific stimulation are normal, but delayed hypersensitivity skin test to candida is negative and the cells are unresponsive *in vitro* to this specific antigen. There is often an association of endocrinopathy. Treatment with topical antifungal agents has limited usefulness; ketoconizole is a new oral antifungal drug that has produced good results in many of these patients with minimal side effects. Specific immunotherapy with transfer factor has been beneficial for some patients.[3]

Severe Combined Immunodeficiencies

Combined humoral and cellular immunodeficiency diseases are not common though they may take many forms. Severe combined immunodeficiency may be an autosomal recessive or X-linked recessive disorder manifested by marked lymphopenia, very low immunoglobulins, chronic diarrhea associated with failure to thrive, and persistent or recurrent infection.[4] These patients lack or have significantly impaired function of both B-cells (quantitative immunoglobulins, specific antibody formation) and T-cells (delayed hypersensitivity skin tests, nonspecific and specific lymphocyte stimulation, lymphokine production). Collagen and skin disorders are common, and there is an association between short-limbed dwarfism and combined immunodeficiency. The chronic diarrhea and malabsorption may be life threatening. *Pneumocystis carinii* pneumonia and graft-versus-host disease are significant complications. Bone marrow transplant from an HLA-matched sibling is the optimal treatment. Fetal thymus and/or liver transplant and other modalities of cellular immune reconstitution, with supplemental administration of gamma globulin, have been tried without much success. Some patients with adenosine deaminase deficiency (another purine salvage pathway enzyme) have responded transiently to packed red blood cell transfusions or have been reconstituted with bone marrow transplant.

Other diseases involving combined dysfunctions

of B-cell and T-cell lines include Nezelof Syndrome (cellular immunodeficiency with quantitatively normal but functionally deficient immunoglobulins), Wiskott-Aldrich Syndrome (immunodeficiency with thrombocytopenia and eczema), Ataxia-Telangectasia (progressive cerebellar dysfunction, IgA deficiency), and Hyper IgE Syndrome (dramatically elevated IgE, eczema, anergy, chronic mucocutaneous candidiasis, deficient antibody responses). Attempts at enhancement of cellular immune function have met with varying degrees of success in all these conditions (Table 2).

Early recognition of these immune deficiencies and referral for immunologic evaluation is imperative. If breast fed, a baby may thrive initially, only to develop manifestations of disease when weaned. Administration of either live viral vaccines or blood products containing viable lymphocytes can have disastrous results in patients with any form of T-cell defect. Corticosteroids are to be avoided in these and all patients with immunodeficiency syndrome.

TABLE 2 — Thymic Defects, Combined Immunodeficiencies, and Treatment Warnings

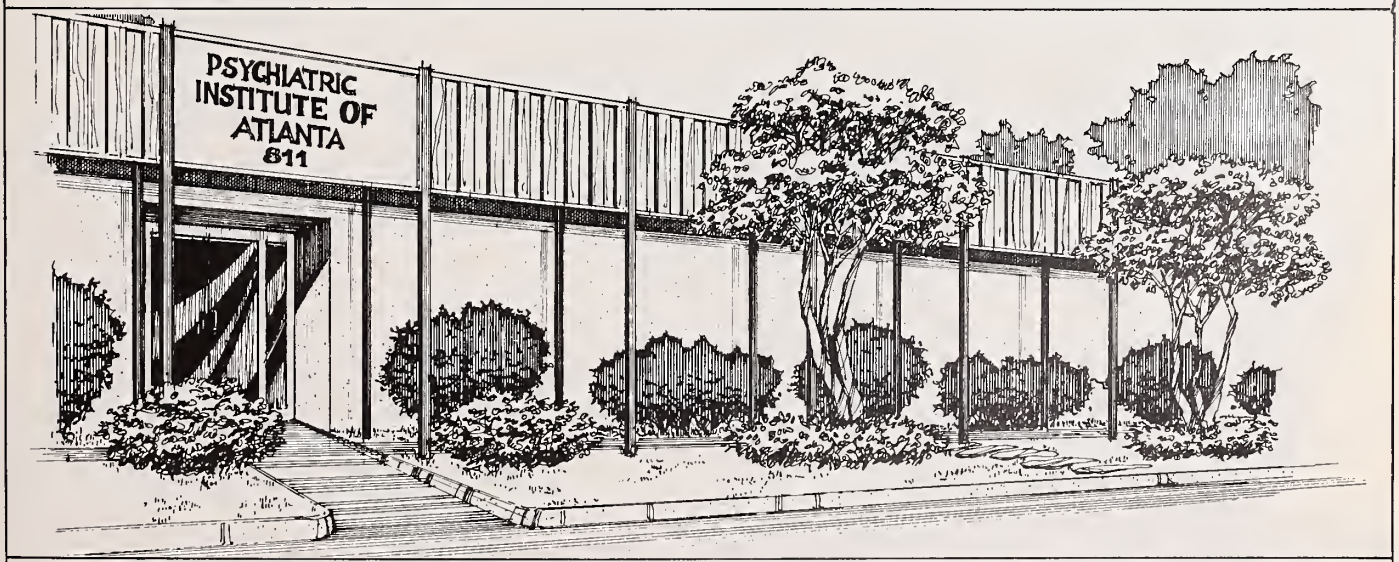
Thymic Defects
DiGeorge Syndrome
Chronic mucocutaneous candidiasis
Combined Immunodeficiencies
Severe combined immunodeficiency
Nezelof Syndrome (Thymic dysplasia)
Wiskott-Aldrich Syndrome
Ataxia — Telangectasia
Hyper IgE syndrome
In any patient with cellular immunodeficiency, avoid:
Live viral vaccines
Blood products containing viable lymphocytes
Corticosteroid drugs

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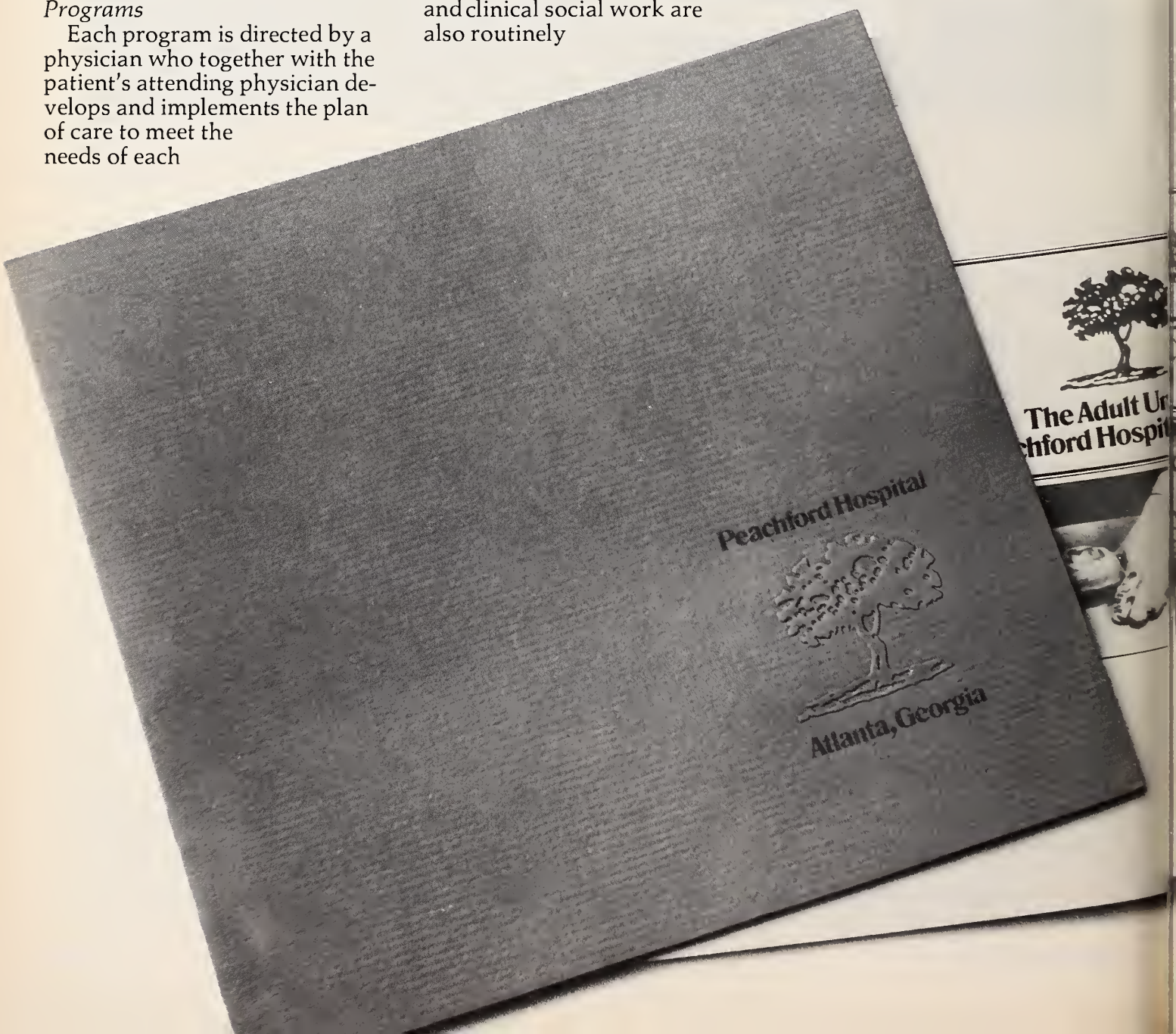
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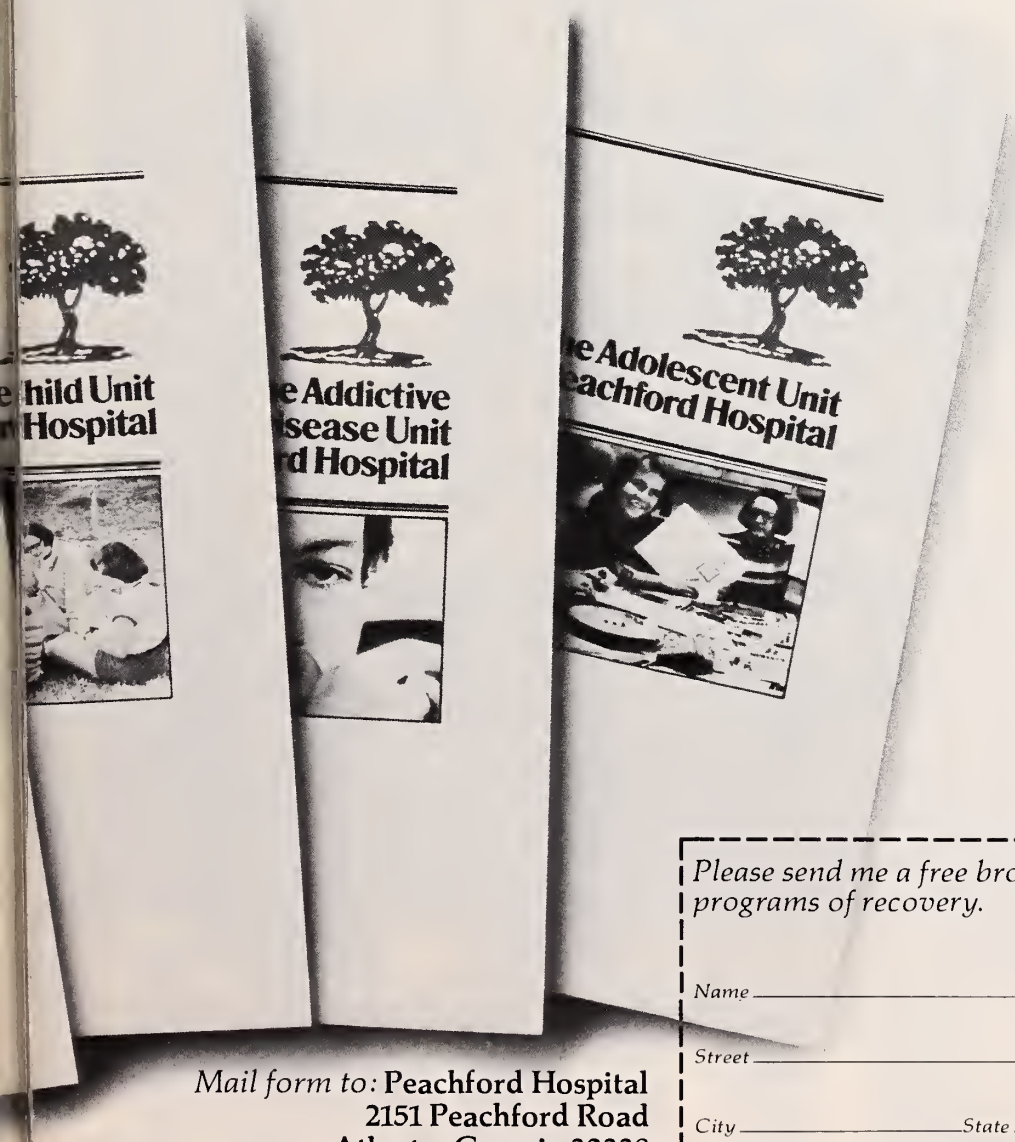
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The 1982 SMA-MAG Scientific Assembly

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C. Rex Teeslink, M.D.
Chairman, MAG Committee on Scientific Assembly
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Examining the "Physician-Patient Privilege" in Georgia

ROBERT N. BERG, *Atlanta**

As most armchair attorneys know, the law holds a special place for "confidential communications." Usually, this "special place" arises through codification in state statutes, whereby communications between certain classes of people — attorneys and clients, or husbands and wives, for example — are not subject to discovery in civil or criminal lawsuits (or, in the words of the Georgia statute, are "excluded from consideration of public policy.").

In Georgia, five classes of communications are deemed to be "confidential communications": (1) communications between husband and wife; (2) communications between attorney and client; (3) communications between or among grand jurors; (4) communications involving secrets of state; and (5) communications between psychiatrist and patient.[1] Perhaps surprisingly, communications between physician and patient are not subject to the statutory "privilege" granted to "confidential communications." Nonetheless, it appears from a recent Georgia case that, despite its omission from the Georgia statute, communications between physician and patient in fact have been elevated in Georgia to a "confidential" status entitled to some degree of protection.

In addition, because of the close interrelationship between the question of whether or not communications are privileged and the question of whether or not physicians are required to produce patient information or records, this recent Georgia case also contains some interesting implications with respect to the requirements concerning the production of confidential patient information and the statutory immunity available to physicians who do so upon prior receipt of proper authorization.

The Physician-Patient "Privilege" in Georgia

In *Orr v. Sievert,* decided by the Georgia Court of Appeals on June 22, 1982,[2] a young child was brought to a hospital by his mother for observation and treatment. The child initially was diagnosed as suffering from the "flu." Appropriate medication was prescribed, and he was released back home in the care of his mother. Several days later, after evidencing signs of physical deterioration, the child returned to the hospital and was admitted as a patient for observation, at which time a tentative diagnosis of meningitis was made, and after which the child was transferred to a second hospital for more detailed examination and treatment.

Ultimately, the original diagnosis was abandoned, and it was determined that the child was suffering from an abscess of the brain. After surgery to remove this and a

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

subsequently diagnosed second abscess, however, the child experienced both physical and emotional changes, and the child's mother brought a medical malpractice action against the physician who originally admitted and treated the child for the "flu," together with his professional association.

As it turned out, the professional association was insured for medical malpractice by the same insurance carrier that insured the physicians who treated the child at the second hospital. As a result, the professional association obtained affidavits from these physicians to the effect that the medical treatment afforded by the original treating physician had been in accordance with accepted medical procedures.

The child's mother then filed an action against the physicians who gave the affidavits, along with the insurer and certain others, alleging that they had conspired to deprive the child of his rights in the suit against the original treating physician and his association by violating the child's right to privacy and violating their implied duty to refrain from disclosing medical treatment involving their patients (the child) without a release, a subpoena, or a request for medical information executed in legal form. The trial court granted summary judgment for all of the defendants, and the mother appealed.

We suggest that physicians closely analyze the request to produce prior to disclosing patient information or producing patient records in cases where there is any doubt as to whether or not the information or records directly relate to the allegations involved in the lawsuit brought by the patient.

Initially, the Court of Appeals faced the question of whether or not communications between a physician and patient were privileged, a necessary question in light of the fact that the mother's subsequent cause of action was premised upon a breach of that privilege by the physicians who provided the affidavits. Despite the fact that the Georgia statute specifying the types of confidential "communications excluded from consideration of public policy" omits communications between physician and patient, the Court concluded that such communications were entitled to a "qualified right to privacy." The Court based its decision on two facts: (i) although there is no statutory patient-physician privilege, the statutory provisions whereby a physician is not required to release information concerning a patient unless required to do so by subpoena or other appropriate court order or authorized to do so by the patient suggests, at least by implication, that the patient has some right to privacy with respect to information concerning the care or treatment rendered to that patient; and (ii) the obligation imposed upon physicians by the Hippocratic Oath to preserve the confidentiality of patient confidences. Moreover, the Court indicated that a physician who violates his or her duty to protect the privacy of his or her patients may be liable for damages incurred by the patients as a result of any unwarranted disclosures.

Once the Court determined that a right of privacy existed under Georgia law which could have been breached by the physician, the Court then turned to the question of whether or not such a breach in fact occurred and concluded that it had not, reasoning that the mother, by bringing the lawsuit, had waived any right to privacy with respect to the patient information concerning her son.

In order to analyze the question of waiver, the Court initially reviewed the last proviso of the Georgia statute dealing with confidential communications, which states:

> "Provided, further, that the privilege shall be waived to the extent that the patient places his care and treatment or the nature and extent of his injuries at issue in any civil or criminal proceeding."[3]

In the Court's view, the mother waived her son's qualified right to privacy by filing a complaint placing in issue the nature and quality of treatment afforded her son,

commencing with the flu diagnosis and ending with the operation for brain abscesses. As stated by the Court:

> "Once [the mother] filed suit questioning the nature and quality of treatment, a doctor having a source of information pertaining to that suit was authorized to release information pertaining thereto and was immune from liability to the patient or any other person for the release of that information. . . .
>
> "To hold otherwise would allow a patient to restrain a doctor who possesses the most relevant information and opinions from responding to inquiries as to such information or giving such opinions without a written authorization, court order or subpoena."[4]

Therefore, the Court affirmed the decision of the trial court granting summary judgment for all the defendants.

Determining the Existence of a Waiver in Connection With Production of Patient Information by Physicians

In past "Legal Pages" in the *Journal,*[5, 6] we have addressed the question of how a physician should respond to a written request from an attorney that the physician produce patient information or records. The focus in those articles involved the Georgia statute providing that: (1) a physician could not be required to produce patient information other than by subpoena or other appropriate court order or if authorized to do so by the patient; and (2) a physician may not be liable to the patient or any other person where the physician releases medical information concerning the patient upon the proper written authorization of the patient, his or her legal representative, or upon court order or subpoena.[7]

Inasmuch as the statutory immunity granted to physicians who produce patient records in accordance with the terms of the statute appeared to be unavailable where the physician produced patient records pursuant to a written request from an attorney (rather than pursuant to a subpoena), we have advised physicians that they may be exposed to some potential liability if they complied with these written requests. Moreover, because of the difficulty which a physician would have in determining, at the time of a written request for production of documents, whether or not a patient had waived any "privilege" or "right of privacy" by placing his or her care or treatment at issue in a lawsuit, we have further advised that such a decision be left to the courts and that physicians, rather than attempting to make their decision, should simply refrain in most cases from producing documents solely on the basis of a written request.

At first blush, the *Orr* decision appears to have significantly reduced the amount of difficulty involved in determining whether or not a patient has placed his or her care or treatment at issue and therefore waived any privilege or right of privacy. As stated by the Court:

> "We discern no restraint upon the doctor who has entered into a patient-doctor relationship and treated a patient from rendering an appropriate opinion as to the nature and quality of treatment afforded the same patient for the same course of illness by another physician where contention has arisen that the treatment afforded has resulted in medical malpractice."

In other words, taken literally, in the situation in which a patient has been treated by more than one physician, the patient will have been deemed to have waived any privilege or right of privacy with respect to the patient's records (including both those records of the first treating physician and those of the second treating physician) if the patient brings a medical malpractice action against either physician. If this accurately assesses the Court's determination, then physicians may find it much easier to produce documents pursuant to a written request in cases involving malpractice claims. While the physicians would not have the benefit of the statutory immunity, they nonetheless would be protected against liability — as

were the physicians in the *Orr* case — because the patient, by bringing the malpractice claim, will have waived any privilege or right of privacy with respect to the information.

A more likely result, however, is that the Court's opinion will be interpreted somewhat narrowly, a result which may also reinstate the problem faced by physicians in determining whether or not a waiver has occurred. For example, the Court stated:

> "Once the patient places his care and treatment at issue in a civil proceeding, there no longer remains any restraint upon a doctor in the release of medical information concerning the patient *within the parameters of the complaint.*"

The italicized language in the above quote suggests that the physician's determination of whether or not a waiver has occurred where the patient brings a malpractice action against another physician may not be an easy one. In the event that the patient information or records produced by the physician dealt with segments of the care or treatment of the patient not involved in the complaint, then it is arguable from the above language that the patient did not waive the privilege or right of privacy with respect to that information and therefore could maintain a cause of action against the physician for breach of the patient's right of privacy.

It appears from [this] recent Georgia case that . . . communications between physician and patient in fact have been elevated in Georgia to a "confidential" status entitled to some degree of protection.

In total, until such time as the *Orr* opinion is interpreted in subsequent cases, it appears that the physician requested by an attorney to produce patient records is in a difficult position. Since the physician most likely will be unaware of the specifics of the medical malpractice complaint at the time that the physician is requested to produce documents, complying with the written request exposes the physician to the risk that, if the court ultimately holds that the patient did not waive his or her privilege or right of privacy by filing the complaint, the physician will be forced to litigate a lawsuit for breach of privacy without the benefit of the statutory immunity. On the other hand, it is also likely that, as a result of the breadth of the Court's decision in the *Orr* case, physicians will be exposed to an increased number of written requests for the production of patient information and records in cases where the patient has brought a malpractice action. Nonetheless, we suggest that physicians closely analyze the request to produce prior to disclosing patient information or producing patient records in cases where there is any doubt as to whether or not the information or records directly relate to the allegations involved in the lawsuit brought by the patient.

[Decisions rendered by the Georgia Court of Appeals are subject to appeal to the Supreme Court of Georgia, which has the power either to affirm or to reverse the decision of the Georgia Court of Appeals, in whole or in part, with or without comment. Accordingly, it is possible that the opinion discussed in this article, although representing the current state of the law in Georgia, may be substantially altered or modified by the Supreme Court. In the event that the case discussed in this article is appealed and subsequently reversed by the Georgia Supreme Court, we will inform you of that decision, once it is reached, in a subsequent issue of the Journal.]

Notes

1. *Ga. Code Ann.* §38-418(a).
2. ____ Ga. App. ____ (June 22, 1982).
3. *Ga. Code Ann.* §38-418(b).
4. *Orr v. Sievert,* ____ Ga. App. at ____.
5. Vincent RH. Civil litigation: physicians' rights and obligations in producing patient records for discovery purposes. J Med Assoc Ga 1978;67:January.
6. Berg RN. Dealing with formal and informal requests for production of patient records. J Med Assoc Ga 1980;69:987.
7. *Ga. Code Ann.* §38-418(b).

Cancer — A Perspective

JOHN P. WILSON, M.D., *Atlanta**

THERE ARE FEW DISEASES which carry more contingencies in the evaluation of future perspectives than does cancer. Despite our increasing knowledge of cancer, despite the areas of marked improvement in survival and apparent cures, many solid tumors still resist efforts to effect a major change in their curability.

It must be understood that any discussion of the shortcomings of cancer management must be prefaced by the comment that the current treatment of cancer overall is relatively good and, with optimum use of present diagnostic and therapeutic techniques, could be significantly better.

The ultimate control of cancer lies beneath the surface of our present knowledge, but scratches here and there are beginning to provide some of the necessary insights into the nature and behavior of cancer that are necessary for its ultimate control.

Some sites, such as colon cancer, have shown progress in the cure rate over the past several decades primarily through early diagnosis and general improvement in the management of the surgical patient. Cancer of the uterine cervix is unquestionably the outstanding example of cancer control by use of a simple and effective diagnostic procedure allowing early treatment. Other sites, such as breast cancer, which at one time had a "standard" treatment, have reached an apogee in the extensiveness of surgery with a subsequent turn to more conservative surgical management. Refinement in radiation therapy has broadened its applicability and reduced its side effects, but its use remains limited to localized areas of disease. Chemotherapy, dramatic in results in some areas of cancer, impressive in combination with radiation and surgery in others, has yet to be established in a major role in the curative management of most solid tumors.

The seeming status quo in the management of many solid tumors has led to ongoing re-evaluation and innovation. A number of questions have been raised within and without the medical profession regarding ideas and attitudes in the management of cancer. Breast cancer serves well as a role model for these questions.

Statistical data comparing lesser surgical procedures with classical radical surgical operations have not shown a remarkable difference. The lack of dramatic improvement in the cure of cancer with radical surgical procedures has led to the re-evaluation of lesser procedures primarily with the idea of improving the quality of life. The observation of adequate local control of disease followed by subsequent death due to systemic disease has led to increasing utilization of chemotherapy both in therapeutic and prophylactic management. The multicentricity of breast cancer has been demonstrated, but this has not translated statistically into demonstrably significant survival figures.

Particularly important has been the pressure from outside the medical profession regarding the patient's role in decision making and management. There has been an

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This article was prepared at the request of the Georgia Division, American Cancer Society.

increasing emphasis of a societal nature regarding the importance of the breast as a factor in the feminine image. There has been, at times, misleading publicity in the lay press concerning the lack of effectiveness of accepted treatment and an over optimism with unproven and unacceptable methods of treatment. There has been, at times, a public interpretation of the process of evaluating results within the medical profession primarily as a manifestation of failure of treatment.

The cosmetic effect of cancer treatment is in essence a non-qualitative factor which lies within the realm of personal opinion. Here, the patient's prerogatives are paramount, for only the patient can establish the value of her appearance or the function of the body. However, the patient's evaluation cannot take into consideration a clear and complete understanding of risk factors which are involved in determining the price to be paid for the cosmetic effect. This attitude has resulted in the questioning by physicians of the results of traditional therapy, the presumption by public and physicians that traditional therapy is relatively ineffective, the increasing use of chemotherapy as an adjuvant, the re-evaluation of radiation as primary treatment, and the use of early reconstructive procedures.

The lack of dramatic improvement in the cure of cancer with radical surgical procedures has led to the re-evaluation of lesser procedures primarily with the idea of improving the quality of life.

We do not have absolute answers. Not only do we lack sufficient data on current treatment protocols, but also we lack, and will for a number of years, information regarding the ultimate effect of radiation and chemotherapy. We are, in essence, required to make irrevocable decisions for individual patients before all the facts are in. This increases the burden upon the physician not only to make proper decisions but also to educate his or her patients to the extent that they can participate in difficult medical decisions. Neither morality nor the law allows us the liberty of arbitrary, unexplained decision making.

Other factors will surely become more important with time. Significant advances in cancer management frequently are the result of work which occurs in areas of basic research. Here lies the ultimate solution to the problem of cancer. The changes in the economy which have already impacted upon many areas of basic research can be anticipated to result in an increasing dearth of financial support in areas which hold great promise for improvement in cancer control. Long-range investigation without immediately applicable results will suffer most.

The impact of legal action regarding the management of patients is no longer a negligible factor. Legal action is no longer confined to cases of gross negligence, but every physician finds himself or herself liable to potential litigation, at times predicated on the idea that physicians should be able to predict the uncertain future.

Through it all, the physician must maintain his/her moral and ethical sense of value in the management of the patient. This requires a familiarity with current data as it can best be interpreted and applied. Consideration of the available expertise and knowledge of current management concepts, all of which must be tempered with the appreciation of the patient's best interest, including his or her coping with the impact on self image. That there may be alternate methods of management with acceptable results does not permit the physician to ignore the needs of a coherent planning concept of the management of a given patient with cancer. He/she must recognize the patient's value scale and appreciate the emotional and psychologic aspects. In turn, it would be an error for the physician to turn the treatment of cancer over to the laymen, not because of the lack of need for input by the patients or consideration of their basic needs but because of the simple fact that patients do not have medical knowledge to make a proper medical decision.

The compassionate physician can understand, appreciate, and consider the patient's emotional and psychologic need as well as the physical need and still not abdicate his responsibilities as a medical expert in determining appropriate therapy.



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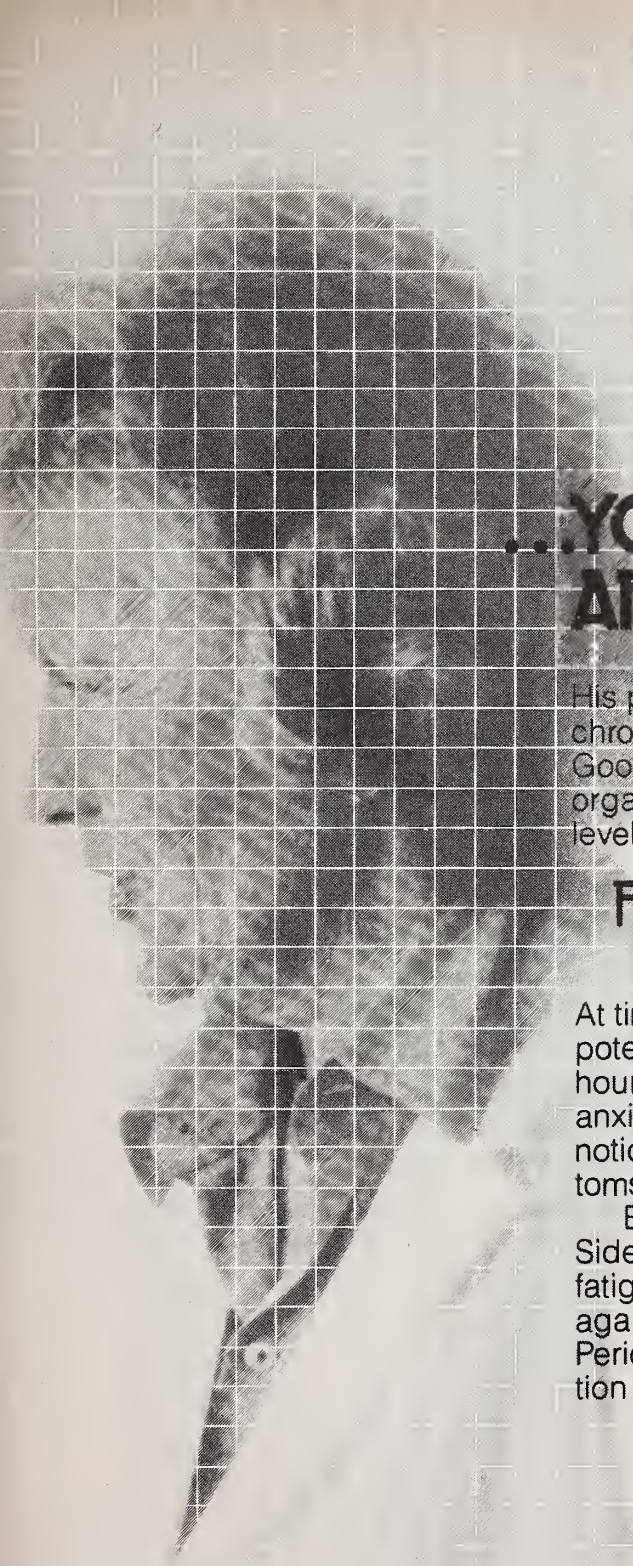
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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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CONTRAINDICATIONS

1) bronchial asthma, 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE: In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levarterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY: Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. *Central Nervous System*: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal*: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic*: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory*: bronchospasm. *Hematologic*: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous*: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings*: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

TABLETS

—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

—Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTABLE

—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).

7997/882

Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

president's letter



Medical Staff Officers Are Organizing

At the June, 1982, AMA Annual Session in Chicago, it was proposed to add a Medical Staff Officers Section at the national meetings. Why should we consider another organization? Wouldn't the same involved physicians simply be assuming more duties? Apparently not, in general. Several significant points were made:

(1) Medical staff officers are more likely to come up through the ranks of the hospital than through medical society activities; they tend to be more informed about hospital administration than physicians at large.

(2) Matters involving hospital staffs are unique. Legal responsibilities involved in activities such as awarding hospital privileges and operating peer review mechanisms are becoming increasingly complex, requiring the combined wisdom and political involvement of us all. Using the forums and the influence of the state and national medical societies allows these problems to be dealt with more effectively.

(3) Hospitals are beginning to enter competitively into the private practice of medicine, and it is appropriate for the physician community to observe, monitor, and advise this activity just as it does the work of the individual practitioner.

(4) Physicians need to become more effectively involved in the training and use of nurses and allied health personnel. Independent efforts by hundreds of hospital staffs can accomplish little in dealing with these challenges.

(5) With the emergence of more and more HMOs and IPAs, the hospitals will be contracting to provide services for these groups. Physicians should be in a position to influence constructively the manner in which these relationships are established and implemented.

We at MAG, recognizing a need, will be using our resources to assist in the organization of medical staff officers in Georgia. This will allow Georgia physicians to develop plans for dealing with future problems. It will also provide an opportunity for delegates from Georgia to influence the national policy.

An organizational meeting is being planned for November, 1982. Start now to inform your colleagues and encourage your hospital staff to have effective representatives at this meeting.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.

NEW MEMBERS

Akstein, Ricardo B., MAA—I&R—OPH
1365 Clifton Rd, NE, Atlanta 30322

Almonte, Ildefonso, Muscogee—Associate—DR
Martin Army Hospital, Fort Benning, 31905

Butler, Jack A., Ocmulgee—ACT—FP
Unadilla Professional Bldg, Unadilla 31091

Byrd, Jeff W., Thomas Area—ACT—PTH
Archbold Memorial Hospital, Thomasville 31792

Chase, Jerry S., Muscogee—ACT—FP
2121 Warm Springs Rd, Columbus 31995

Cooper, Jerry D., MAA—ACT—NEP
1938 Peachtree Rd, NW, Ste 303, Atlanta 30309

Darugar, B. Barry, Oconee Valley—ACT—GS
2 Hospital Perimeter Rd, P.O. Drawer 760, Eastman 31024

Deaton, Burrell H., DeKalb—ACT—D
4399 LaVista Rd, Tucker 30084

DiCristina, Michael A., Spalding—ACT(N-2)—IM
571 S. 9th St, Griffin 30223

DuVall, David W., Flint—ACT—IM
208 Second Ave E, Cordele 31015

Evans, Raymond C., Tift—ACT (N-2)—R
212 Victor Dr, P.O. Box 388, Tifton 31793

Fielder, Dennis L., MAA—ACT—AN
Dept. of Anesthesiology, Northside Hospital, Atlanta 30342

Hooper, Donald, MAA—ACT (N-2)—OPH
1844 Cedar Creek Dr, Atlanta 30345

Kistler, Henry E., Stephens-Rabun—ACT—OBG
905 Big A Rd, Toccoa 30577

Lawrence, Douglas R.,
Floyd-Polk-Chattooga—ACT—OBG
1105 N. Fifth Ave, Rome 30161

Levy, Lawrence H., DeKalb—ACT (N-1)—IM
497 Winn Way, Ste A-240, Decatur 30030

Malloy, Tyrone C., DeKalb—ACT (N-2)—OBG
2853 Candler Rd, Ste 4, Decatur 30034

Shaw, George P., Jr., Walker-Catoosa-Dade—ACT (N-2)—FP
105 E. Patton, LaFayette 30728

Sinclair, Carter H., Muscogee—ACT—FP
Family Practice Pavillion, The Medical Center, Columbus 31901

Ware, Charles I., Stephens-Rabun—ACT—GYN
P.O. Box 788, Toccoa 30577

PERSONALS

First District

Leonard S. Wojnowich, M.D. has joined the practice of family medicine at 58-B Oglethorpe Mall in Savannah. Dr. Wojnowich received his medical training at the University of North Carolina and served a 3-year residency at Memorial Medical Center.

Willingway Hospital in Statesboro has named **Al J. Mooney, III, M.D.,** as its Medical Director. Dr. Mooney chairs Georgia's American Medical Society on Alcoholism.

Claxton general surgeon, **Marcelo R. Santiago, M.D.,** and Hinesville general surgeon, **J. Ruben D. Silan, M.D.,** were elected secretary and treasurer, respectively, of the Philippine American Medical Association of Georgia for 1982-84.

Second District

Steven C. Chao, M.D. has moved his obstetric and gynecology practice to Camilla. He practiced previously at the University of California at San Francisco Medical Center.

Fifth District

John T. Godwin, M.D., of Atlanta, who is currently serving as Chairman, Department of Pathology and Laboratory Medicine, King Faisal Specialist Hospital and Research Centre, Riyadh, Saudi Arabia, recently returned to Atlanta for a visit.

Dr. Godwin has been appointed editor of the CPC section of the King Faisal Specialist Hospital Medical Journal. He recently established a nation wide Pathology Slide Seminar for pathologists of Saudi Arabia and adjoining Mideast countries.

Steven J. Morris, M.D., of Atlanta, was elected to Fellowship in the American College of Physicians. Dr. Morris, a gastroenterologist, will be honored at the Convocation ceremony at the College's Annual Session in San Francisco in April of 1983.

Seventh District

Internist **Grant Lewis, M.D.,** of Rome, was appointed President of the Medical Staff at Redmond Park Hospital for the 1982-83 term. Dr. Lewis is a member of the Rome Chamber of Commerce and the Rome Exchange Club.

Calhoun family practitioner, **Dewey Hammond, M.D.,** recently attended an Advanced Trauma Life Support course in Chattanooga. The course is designed to improve physician's skills for treating emergency patients.

Raymond C. Corpe, M.D., a general surgeon in Rome, retired recently from the Northwest Georgia Regional Hospital. Dr. Corpe did much of the clinical research for the drugs used to treat tuberculosis, including Streptomycin, introduced in 1945, and Isoniazid, introduced in 1952. Northwest Georgia was, until a decade ago, Battey State, the nation's largest hospital for the treatment of TB. Dr. Corpe was director of Battey for many years. He and his staff compiled the reference manuals for physicians to treat patients with TB. Dr. Corpe also served as a consultant to other hospitals in the Southeast and helped completely change statewide programs for TB.

Ernest F. Daniel, M.D., was recently elected President of the Georgia Neurosurgical Society. Dr. Daniel is also President of the Medical Staff of Doctors Hospital and has been a member of that hospital's Board of Trustees for 10 years.

William B. Strong, M.D., F.A.C.C., of Augusta, has been selected to serve on the Scientific Program Committee of the 32nd Annual Scientific Session of the American College of Cardiology slated for March 20-24, 1983. This committee will be responsible for planning and structuring the educational programming for the upcoming annual meeting in New Orleans.

Tenth District

Romulo L. Parungao, M.D., a general surgeon from Conyers, was recently installed as the fourth President of the Philippine American Medical Association of Georgia at its Eighth Annual Scientific Conference at Callaway Gardens held July 15-18.



Dr. Romulo Parungao

SOCIETIES

The Floyd-Polk-Chattooga Medical Society sponsored the 23rd annual meeting of the Georgia State Society, American Association of Medical Assistants (AAMA) in Rome, last April. Charles Sennett, M.D., president of the county medical society, addressed the AAMA group. Educational sessions, one co-sponsored by the MAG, were conducted, and a variety of awards were presented. The Physician Advisory Board for the Georgia Chapter of the AAMA includes Alvin H. Clair, M.D. (Rome), Chairman, Sidney A. Bell, M.D. (Rome), Richard Ellis, M.D. (Valdosta), Frank Middleton, III, M.D. (Albany), and Minor Vernon, M.D. (Macon).

Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located less than 20 minutes from downtown Atlanta. Ridgeview offers three individual, fully-accredited, separately-housed programs in alcohol and drug treatment, adult, and adolescent psychiatry.

A full range of treatment methods are available and a high staff-patient ratio assures individualized attention. Bright, warm colors and sunny interiors provide a non-institutional atmosphere as patients participate in a wide range of theraupetic and recreational activities.

Alcohol & Drug Program

This program offers a multi-dimensional treatment and rehabilitation program aimed at helping those afflicted with the disease of alcoholism or drug addiction. A variety of groups and activities are led by trained, experienced addiction counselors and therapists. Alcoholics Anonymous and Narcotics Anonymous are intrical parts of the program.

Adult Psychiatric Program

Under the psychiatrist's leadership, patients on the adult unit are treated individually for depression, anxiety, schizophrenia, manic depressive illnesses, personality disorders and other similar disfunctions. The physician and treatment team work closely together on the patient's assets as well as problems in the social, psychological and physical areas.

Adolescent Program

This unique program offers a wide range of treatment modes and emphasis is placed on resolving the emotional, behavorial and educational difficulties involving this age group. A fully accredited school lets the young people continue their education during the inpatient process. Classes are small and credits earned at Ridgeview are transferred back to their schools.

Ridgeview INSTITUTE

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Smyrna, Georgia / (404) 434-4567

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- VALLEY HOSPITAL HAS 100 LICENSED BEDS AND IS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.
- THE HOSPITAL IS LOCATED AMIDST 80 ACRES OF BEAUTIFUL WOODLANDS, JUST TWENTY MINUTES FROM DOWNTOWN CHATTANOOGA.
- VALLEY HOSPITAL IS AN AFFILIATE OF HOSPITAL CORPORATION OF AMERICA, WHICH MAINTAINS A COOPERATIVE NETWORK AMONG THE 360 HCA AFFILIATED HOSPITALS.
- THE TREATMENT PROGRAMS AT VALLEY ARE DIVIDED INTO THREE MAJOR AREAS: **THE ADULT PROGRAM, THE ALCOHOL AND DRUG PROGRAM, AND THE ADOLESCENT PROGRAM.** THESE PROGRAMS ARE SERVED BY A COMPLETE RANGE OF TREATMENT THERAPIES AND ACTIVITIES PROVIDED BY A WELL TRAINED PROFESSIONAL STAFF.

FOR THOSE WHO COME TO VALLEY IN NEED OF HELP, WHETHER IT BE FOR THE DISEASE OF ALCOHOLISM, DRUG DEPENDENCY, EMOTIONAL PROBLEMS, THE TEENAGER UNABLE TO COPE WITH THE GROWING-UP PROCESS, OR ANY OF A BROAD RANGE OF PSYCHIATRIC DIFFICULTIES, WE SAY: "WELCOME, YOU HAVE JUST TAKEN THE FIRST STEP TO RECOVERY."

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VALLEY IS PEOPLE:

THE PATIENTS:
WHO DESERVE OUR COMMITMENT TO QUALITY CARE, CONFIDENTIALITY, AND PROFESSIONALISM.

THEIR FAMILIES:
WHO SHARE OUR CONCERN FOR THE PATIENT'S WELL BEING AND HOPES FOR THE FUTURE.

THE STAFF:
WHO WORK WITHIN THE HOSPITAL TO PROVIDE THE BEST POSSIBLE TREATMENT AND ENVIRONMENT FOR EACH PATIENT.

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Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from April through June, 1982.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category 1 credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Norman Abramson, Macon
Bipin B. Agrawal, Columbus
Richardo B. Akstein, Tucker
Hortensia W. Alvarez, Milledgeville
Philip Bates Bailey, Dalton
John G. Bates, Cuthbert
Robert W. Beard, Savannah*
Paul E. Beecham, Roswell
Joseph A. Blissit, McDonough
J. Larry Boss, Villa Rica
Stewart D. Brown, Royston
Charles Saunders Burke, Fort Gordon*
William Chapman Butz, Decatur*
George M. Callaway, Jr., Decatur
Larry V. Clements, Marietta
Sara Louise Colby, Decatur*
Chappell A. Collins, Jr., Albany
Rudolf A. Colmers, Savannah
Floyd R. Cooper, Jr., East Point
Frank T. Corker, Valdosta
Daniel Baker Cox, Waycross
Charles H. Crabbe, Jr., Augusta*
Laurence T. Crimmins, Albany
John M. Crymes, Savannah
James E. Darden, Columbus*
Billy Joe Davis, Hartwell
Dave McAlister Davis, Atlanta
Bruno Denis, Hapeville*
James C. Dismuke, Adel
Asa D. Duggan, Washington
Edgar Mullins Dunstan, Decatur
James Kevin Elsey, Stone Mountain*
Ilhan Ermutlu, Atlanta
Richard Emerson Felder, Atlanta
M. Lynn Ferrell, Sparta
John M. Fillingim, Savannah
Carol W. Flythe, Atlanta
Luther G. Fortson, Jr., Marietta
John Edward Fowler, Clayton
Leroy Robert Fullerton, Fort Benning*
Homer L. Gold, Canton
Richard Miles Goldberg, Atlanta*
Fairfield Goodale, Augusta
Carey W. Goodman, Statesboro
E. Rawson Griffin, III, Fort Benning
Mary Anne Tyler Hagler, Augusta
Jefferson D. Hanks, Jr., Rome
William N. Harper, Atlanta
Theodore R. Hatfield, West Point
Charles M. Hendricks, Dublin
David Hleap, Cumming*
Nguyen Van Hong, Augusta*
Douglas C. Huber, Douglasville
William Mitchell Jacob, Atlanta*
Jack R. Jarvis, Decatur
Barry F. Jeffries, Atlanta*
John Richard Jones, Hinesville*
Nayereh K. Khankhanian, Augusta*
Zachary M. Kilpatrick, Augusta
Stephen King, Atlanta
Paul A. Kirschbaum, Atlanta*
Jonathan S. Krauss, Augusta
Roy Glenn Kreusel, Fort Gordon*
James W. Lewis, Albany
Patricia K. A. Lloyd, Atlanta*
William S. Mayberry, Watkinsville*
John H. McFarland, Rome
Eugene C. McMillan, Macon
Archibald A. McNeill, III, Camilla
Jack Reeves Meacham, Summerville*
Jonathan Ray Merrill, Atlanta
Steven Curtis Moreland, Atlanta
John G. Morrow, Athens*
Ui Ho Park, Dublin*
Pankaj T. Patel, Dublin
Henry S. Pepin, Thomasville
Juan A. Perez-Enriquez, Milledgeville
Gary Lynn Petry, Norcross
Louis Michael Prisant, Augusta*
Martin S. Pritzker, Savannah
Clarence W. Rawson, Jr., Savannah
John Edward Riffle, Fort Gordon*
John Peter Rissing, Augusta
Theresa M. Romzick, Cumming*
Gil Domingo Saguiguit, Moody AFB*
John Sandberg, Smyrna
Robert Orville Schoffstall, Macon*
Robert S. Shacklett, Thomaston
Ivy Lee Shuman, Sylvania
George L. Smith, Columbus*
Margaret J. Sommerville, Atlanta
Jerry Ewing Squires, Augusta*
John R. Stephenson, Columbus
Rick K. St. Pierre, Decatur
David Manning Stubbs, Bainbridge*
Rene A. Tapia, Decatur
Martin O. Taruc, Augusta*
Jeffrey Lewis Tate, Decatur*
John N. Tripp, Macon
Joseph M. Turner, Tifton
Melvin M. Udel, Smyrna*
Bozidar F. Voljavec, East Point
Charles B. Watkins, Chamblee
William R. Watson, Toccoa*
Harvey Alan Weiss, Atlanta
Roy A. Wildey, Savannah
Louis J. Wilhelmi, Augusta*
Frederick R. Witten, Tucker*
William J. Wylie, Augusta
Lionel M. Yoe, Columbus
Henry F. Yost, Gracewood

* Non-MAG member.

Committee Activities . . .

(At the July 11, 1982, MAG Executive Committee meeting, the chairmen of several committees reported on their committees' current activities and future plans. Presented below are summaries of those reports. Read them and become better informed about your Association.)

Public Relations Committee

A public opinion survey will be conducted by the New York firm of Kane, Parsons & Associates, Inc., a nationally known survey and opinion research firm. Some 400 Georgia citizens, selected from all parts of the state, will be contacted by phone and interviewed on such topics as how they selected their personal physician; how they feel about doctors' fees; how confident they are that they have enough money to pay for a major illness; if they engage in rigorous activity on a weekly basis; how they feel about the length of time they are seen by a physician, etc. The survey to be conducted in Georgia will be done in conjunction with a survey commissioned by the American Medical Association in a nationwide sampling. The results of the survey should be available this fall.

The PR Committee is continuing to distribute the "I Want To Know What You Think" brochures. To date, over 150,000 have been distributed and more orders continue to come in. These are distributed to physicians' offices at the rate of $2.00 per 100. All MAG members who have not availed themselves and their patients of the brochures are encouraged to do so.

The PR Committee has worked closely with the Transfusions and Transplantations Committee along with the Georgia Lions Eye Bank, the Kidney Foundation, the Atlanta Regional Organ Procurement Agency (AROPA), and others to produce 30-second public announcements which have been distributed to all of the state's TV stations. These announcements concern the importance of donating one's organs so that others may live more productive lives. The Georgia Lions Eye Bank has honored the MAG for its cooperation in informing the public of this project.

A meeting was held between MAG officials and the editorial board of the *Atlanta Journal* to better communicate the concerns between the respective organizations. As a result of this meeting, MAG hopes to have a better relationship between not only the editorial board of the *Atlanta Journal* but also with the paper's health and science writers as well.

All MAG committeemen have been sent letters from the PR Committee Chairman requesting information concerning the work of their respective committees which may be publicly disseminated. The PR Committee feels there are a great many positive things happening in medicine today that the public should be made aware of.

We have purchased video equipment which will assist MAG's efforts in providing health related programming to the electronic media.

A number of our auxiliary chapters are continuing with our "For Good Health" radio series. All auxiliary chapters are encouraged to initiate the programming. MAG staff is available to assist in this effort.

The charge of the Public Relations Committee is to provide advice, assistance, and coordination for all of the committees on communications with the membership and the public.

Charles W. McDowell, Jr., M.D.
Chairman

Committee on Third Party Relations

The Committee on Third Party Relations was established to promote liaison with health insurers, private and public, in order to provide a forum for discussion of physician-insurer problems and to investigate the insurer's basis of reimbursement, methods of claims processing, and benefit packages available; and to review federal and state health programs and make their findings on programs available to the MAG membership.

One of the major objectives of the Committee is to try to get insurance companies to offer incentives to the public and to physicians. These incentives will be delineated and discussed below. It is the desire of the Committee to work closely with the Committee on Education and the Committee on Cost Awareness to achieve the following goals:

(1) to encourage good health practices implemented through the committee and the insurance companies,
(2) to encourage good health practices in educational programs implemented through the school systems,
(3) to encourage insurance companies to provide incentives to the doctors of Georgia for limiting patient admissions to hospitals,
(4) to encourage the insurance companies to provide incentives to policyholders to limit the use of their hospital insurance,
(5) to encourage the health insurance industry to utilize existing PSRO, and
(6) to encourage the continuation of the Medical Association of Georgia's input into medicine/business coalitions.

A. A. McNeil, M.D.
Chairman

Maternal and Infant Health Committee

The Maternal and Infant Health Committee is an active committee which attempts to keep abreast of maternal and infant health in Georgia and maintains liaison with the Department of Human Resources and the Maternal Infant Health Council. The committee reviews all maternal deaths in Georgia where the information is available, keeps abreast of legislative activities in Georgia which impact on maternal and infant health and any other related maternal and infant health matters brought to its attention.

Many of the health problems of Georgia mothers and infants are unfortunately among patients who are dependent on public health and other publicly supported hospitals, agencies, and clinics.

The committee wishes to call to MAG's attention the problems in decreasing federal maternal and infant health funds allotted to Georgia and in decreasing Medicaid funding. There is concern that family planning, immunization for children, prenatal and obstetric care, well child care, the maternal and infant care projects, and crippled children's programs will have great difficulty in surviving and providing services to this needy segment of Georgia's citizens.

The goals of the Maternal and Infant Health Committee for 1982-83 are as follows:

(1) Review maternal deaths in Georgia.
(2) Review blood availability to hospital obstetric services and recommend improved blood product use and distribution, including physician education.
(3) Foster the best care for mothers and infants within funding limits and push priority for block grants and state funds to be used to prevent mortality and morbidity among mothers and infants and for the greatest possible prevention of unwanted and unwed pregnancy in Georgia, especially among teenagers.
(4) Continue to monitor legislation and regulations impacting on the health care of mothers and infants, provide liaison between agencies providing health care of mothers and infants, and recommend to the Executive Committee any measures to improve the health of mothers and infants of Georgia.

Luella Klein, M.D.
Chairman

Medical Practice Committee

This committee was established to study health care financing and national health insurance; to promote liaison between physicians and hospitals and their organizations; and to encourage the private practice of medicine.

Each year, the Medical Practice Committee has the opportunity to address a number of issues that relate to the private practice of medicine. Health care financing and national health insurance are currently on the "back burner" of this committee. Both are being monitored. Most health care financing issues are also being considered in the arena of cost awareness. National health insurance per se does not appear to be a viable issue at this time. Various proposals at both the federal and state levels are being watched.

With this in mind, the Medical Practice Committee specifically wishes to promote liaison between physicians and hospitals and their organizations as a primary goal for 1982-83. Our objectives are to (1) sponsor or cosponsor a statewide meeting on hospital-medical staff relations; (2) study the issue of resuscitation guidelines; (3) seek further information about "therapeutic substitutions" in hospitals; and (4) work with the appropriate agencies to implement a voluntary 48-hour delay in filling prescriptions for amphetamines and preludin.

Cost Awareness Committee

The Cost Awareness Committee has been charged to study health care costs in an effort to control their rise without reducing the quality of care available to patients; to interact with similar committees at the hospital and county medical society level in order to share information on costs; and to make recommendations to the MAG Board of Directors or the House of Delegates to establish MAG policy positions on controlling the rising costs of health care.

Our goals and objectives are to continue to work with the Georgia Voluntary Effort (GaVE) to make it a more effective mechanism for cost awareness; to help establish at least one business-medicine coalition; and to identify and help initiate one or more specific cost awareness program(s), such as ambulatory surgery and/or utilization review projects. We want to work more closely with hospital medical staffs to increase cost awareness in the hospital setting, and routinely make cost awareness suggestions either from MAG's official positions or as gleaned from other sources. We plan to develop proposals for the medical staffs participating in the GaVE.

H. Duane Blair, M.D.
Chairman

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10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socio-economic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]



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Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.
Contraindications: Hypersensitivity to any component.
Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
Precautions: *General.* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient.* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions.* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
Adverse Reactions: Adverse reactions have been reported with specific vitamins and

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5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]



minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

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A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

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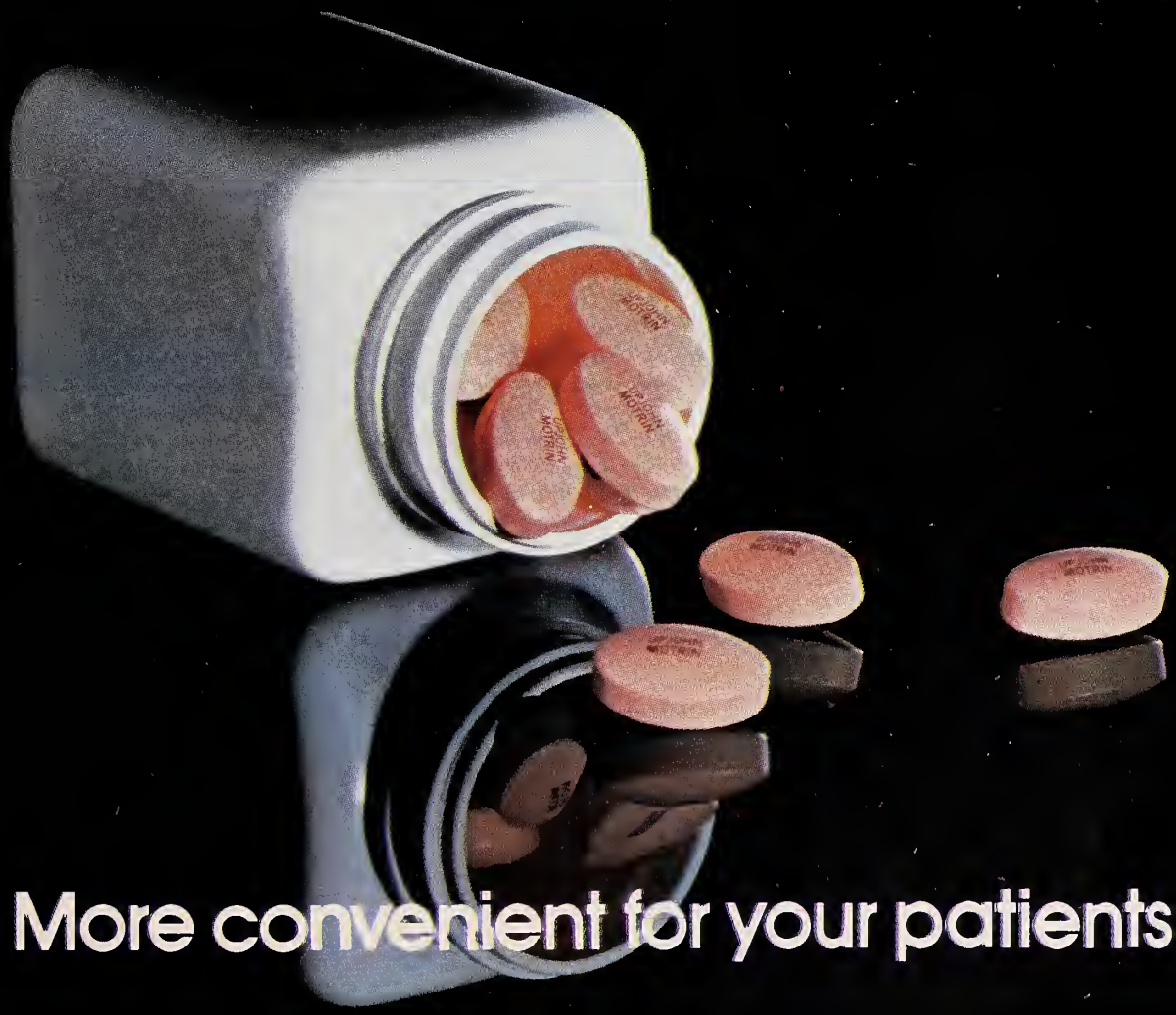
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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

Efficacy objectively demonstrated in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.

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The efficacy of Dalmane has been studied in over 200 clinical trials with more than 10,000 patients.[3-15] During long-term therapy, which is rarely required, periodic blood, kidney and liver function tests should be performed. Contraindicated in patients who are pregnant or hypersensitive to flurazepam.

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References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **4.** Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*(10):25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **14.** Kales A, Kales JD: *Pharmacol Physicians 4*(9):1-6, Sep 1970. **15.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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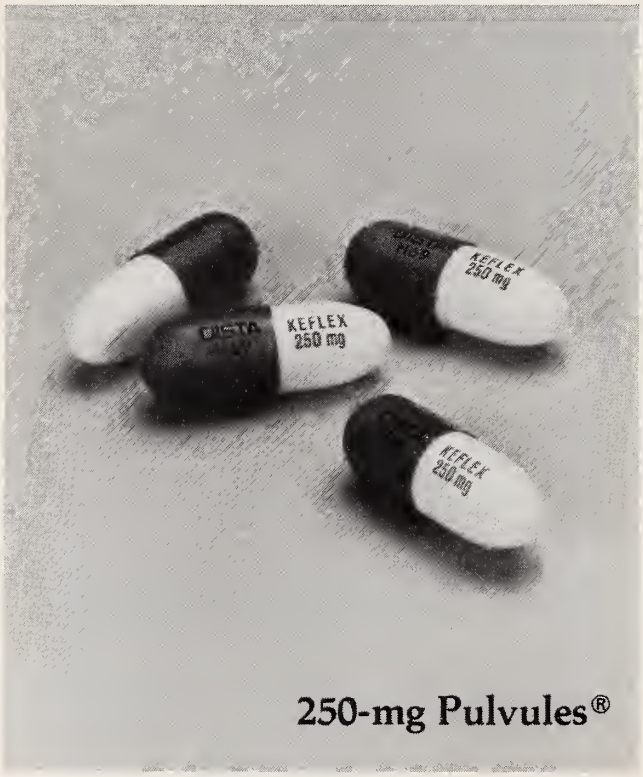
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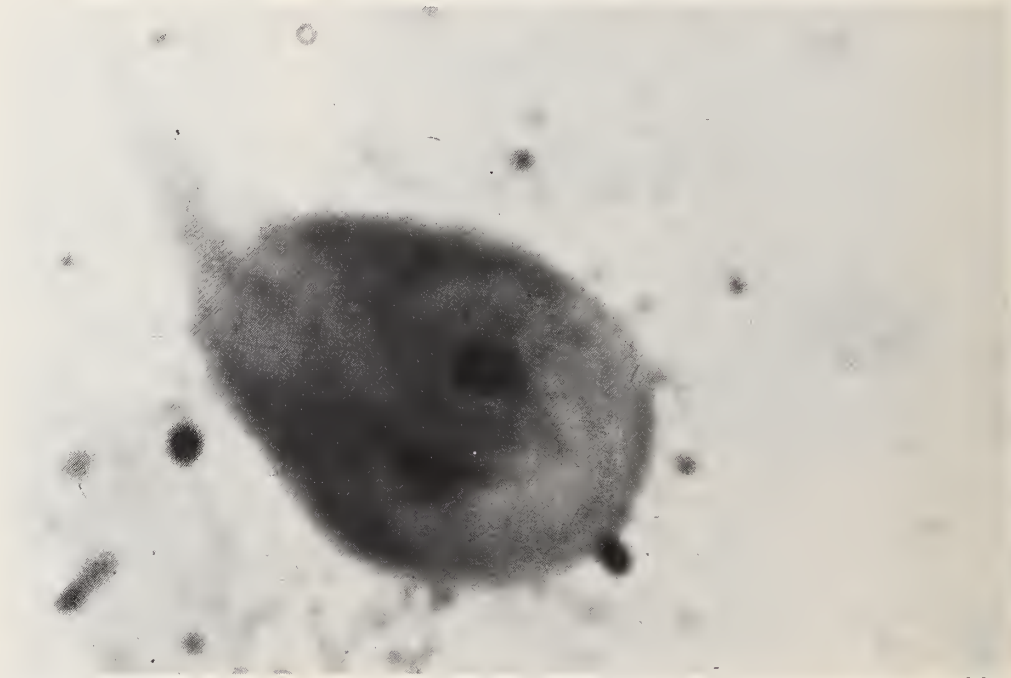
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include Giardia lamblia (motile trophozoites), Strongyloides stercoralis (larvae and/or eggs in advanced stages of development), Clonorchis sinensis (eggs), Fasciola hepatica (eggs), Trichostrongylus orientalis (eggs), and Isospora (coccidia).

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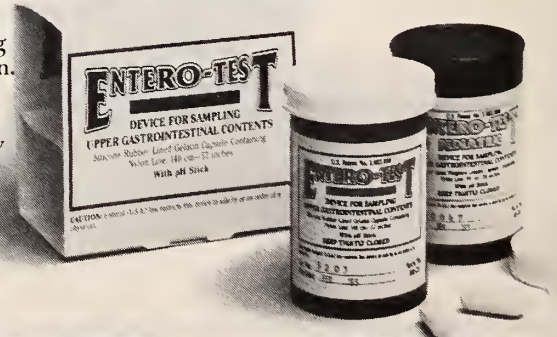


Giardia lamblia

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

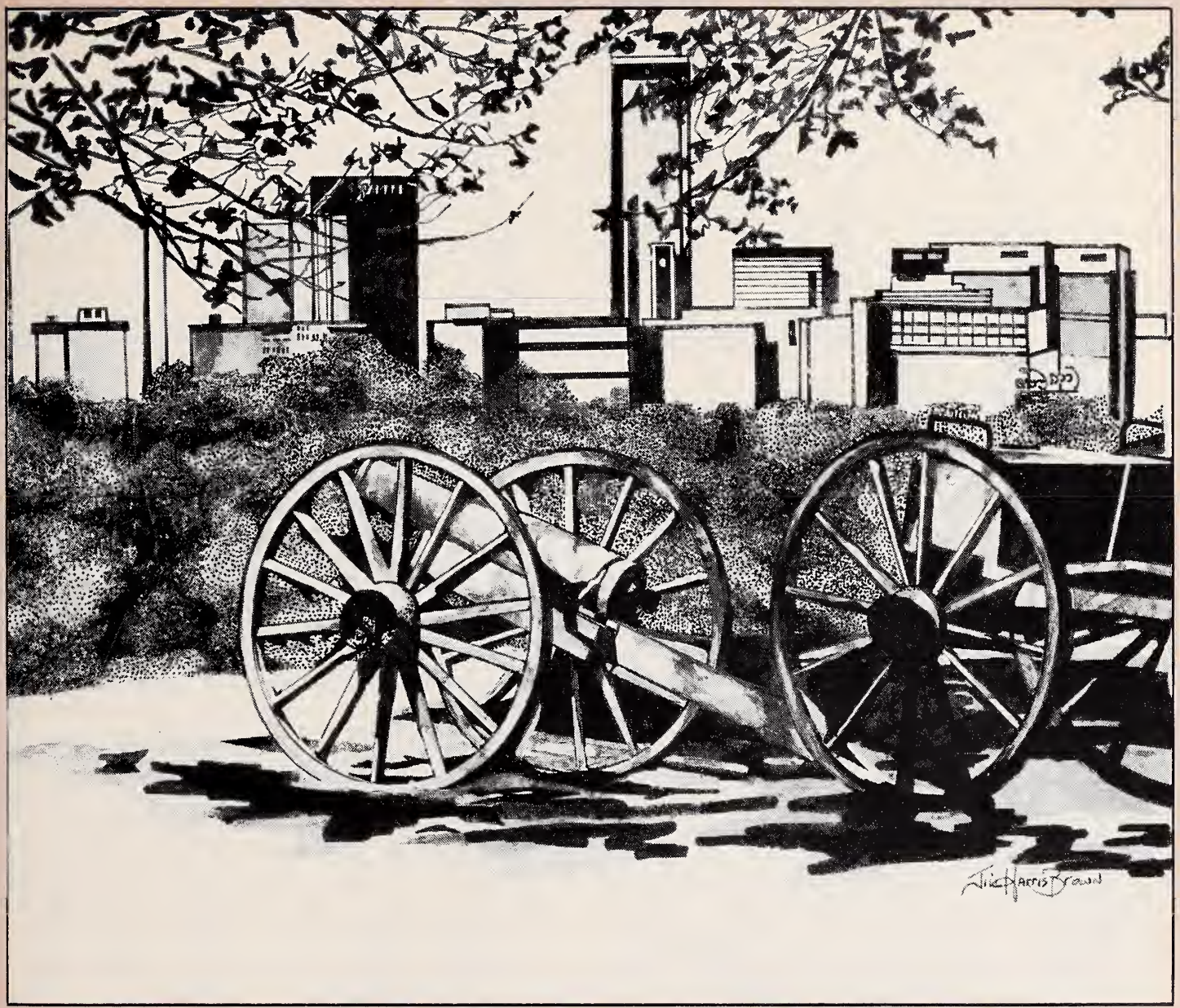
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The Program at a Glance
SMA-MAG Scientific Assembly
Georgia World Congress Center, Atlanta, October 30-November 2

SATURDAY		SUNDAY		MONDAY		TUESDAY
A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.
Anesthesiology	Chest Diseoses	Anesthesiology	Allergy	Gostroenterology	Chest Diseoses	
Chest Diseoses		Dermotology Clinicol Session		Emergency Medicine		
Medicine	Medicine	Emergency Medicine	Gynecology	Southern Gynecologicol & Obstetricol Society	Gostroenterology, Colon & Rectol Surgery, Rodiology, ond Surgery	George Poponicoloou Memoriol Seminor (Gynecology, Obstetrics, Pothology, ond Rodiology)
		Medicine			Emergency Medicine	
Neurology/ Neurosurgery	Neurology/ Neurosurgery	Neurology, Neurosurgery, & Psychiotry		Neurology, Neurosurgery, & Psychiotry	Obstetrics	
Otoloryngology		Otoloryngology				Seminor Grond "Tox" Rounds— 1982
Pothology	Pothology	Pothology	Pothology	Otoloryngology ond Allergy	Dermotology	Dermotology
					Pothology	
Pediotrics	Pediotrics	Pediotrics	Disto Symposium Sports Medicine for the Fomily Physicion	Burks-Cooper Clinicopothologic Seminor (Dermotology ond Pothology)	Fomily Proctice	
Psychiotry	Psychiotry			Fomily Proctice	Orthopedic & Troumotic Surgery	Orthopedic & Troumotic Surgery
				Urology		
Rodiology	Rodiology	Rodiology, Urology, ond RSNA	Urology, Rodiology, ond RSNA	Rodiology	Urology	
				Orthopedic & Troumotic Surgery		
PGC G1 Infectious Diseoses 3 hours		Orthopedic & Troumotic Surgery	Orthopedic & Troumotic Surgery	Plostic & Reconstructive Surgery	Plostic & Reconstructive Surgery	
PGC G2 Rheumotology 3 hours	PGC G7 Venomous Bites: Snokes, Scorpions, ond Spiders 3 hours	Surgery	Colon ond Rectol Surgery	9:00-10:30 Colon & Rectol Surgery		
				9:00-10:30 Surgery		
PGC G3 Fluids ond Electrolytes 3 hours	PGC G8 Ophtholmology for the Non-Ophtholmologist 3 hours		Surgery	11:00-12:00 Colon & Rectol Surgery ond Surgery		
PGC G4 Cordiology Updote 3 hours— Sundoy A.M. 3 hours	PGC G9 Evoluotion ond Treotment of the Potient with Dizziness 3 hours	PGC G4 Cordiology Updote (continued)	PGC G12 Colonic Dis-Orders: Clinicol Updotes for the Primory Core Physicion 3 hours	PGC G13 Neurology 3 hours	PGC G18 Adolescent Sports Medicine 3 hours	
				PGC G14 Pediotric Endocrinology 3 hours		
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Morning Sessions: 9:00 A.M. **Afternoon Sessions: 2:00 P.M.**

Highlights of this upcoming scientific meeting are detailed.

SMA-MAG Scientific Assembly

October 30-November 2, 1982 **Georgia World Congress Center** **Atlanta**

The Medical Association of Georgia is once again proud to plan its 8th Annual Scientific Assembly in conjunction with the 76th Scientific Assembly of the Southern Medical Association. As in 1978, when the two associations held their first conjoint meeting, there will be many out-of-state attendees, and the Georgia World Congress Center will provide a spacious and attractive setting. Guests will stay at one of three downtown hotels reserved for the Assembly — Peachtree Plaza, Omni International, and Hyatt Regency.

Over 300 hours of continuing medical education credits will be offered through 50 scientific sessions in virtually every specialty. In addition, 19 postgraduate courses will be conducted. And all this does not touch upon the many social functions. Added features are an ample program for spouses and a full array of technical and scientific exhibits.

Scientific Programs

Scientific programs in 21 major specialties will run from Saturday morning, October 30, to Tuesday noon, November 2. Following SMA's traditional format, most specialty sections will feature distinguished guest speakers and submitted papers by other speakers. Specialty societies in Georgia have also played a role in the selection of speakers. Each state or local society is represented by a program chairman who has worked with SMA's respective section secretary in designing the program. Postgraduate courses will offer in-depth education in a variety of special clinical topics. Some courses are listed under their specialty headings; others are listed at the end of this special section of the *Journal*. Please take notice of the course on "Nutrition Fads," which was planned through the MAG Committee on Nutrition.

Registration

There will be NO registration fee for attendees of the Scientific Assembly, but to cover the expense of faculty, each postgraduate course has a designated fee, and pre-registration is required. For the purpose of this conjoint Scientific Assembly, all Georgia physicians will be considered as SMA members and hence will qualify for the reduced course fees. Physicians planning to attend the SMA-MAG meeting should pre-register by using the registration form found in this *Journal* or in the SMA preliminary program. The complete program is found in the August *Southern Medical Journal*, copies of which have been mailed to all Georgia physicians.

Registration desks will be open in the Georgia World Congress Center Saturday, October 30, through November 1, 8:00 am-5:00 pm, and Tuesday, November 2, 8:00 am-12:00 noon. Those wishing to register early may do so at the Peachtree Plaza Hotel on Friday, October 29, 8:00 am-5:00 pm.

For Further Information

This issue of the *Journal* contains a summary of the SMA-MAG Preliminary Program. For a copy of the complete program, please contact Stephen Davis, Director of Education, MAG, 938 Peachtree St., NE, Atlanta 30309; phone 876-7535 or 800/282-0224 (toll free in Georgia). For more information, please contact Jeanette Stone, Program Development Coordinator, SMA, 2601 Highland Ave., Birmingham, AL 35205; PH:205/323-4400.

Social and Recreational Events

The SMA President's Reception, honoring Edwin C. Evans, M.D., of Atlanta, will be held at the

Peachtree Plaza Hotel, Saturday night, 7:00-8:30 pm. On Monday afternoon, 12:15 pm in the Omni International Hotel, Edwin Newman will give an address at the President's-Doctors' Day Awards Luncheon. That night, at the Peachtree Plaza, the annual SMA Dinner Dance will begin at 7:30, after a hospitality hour at 6:30. Pat Boone and the Ray Bloch Orchestra will provide the entertainment. Tickets for the luncheon are $15 each; for the dinner dance, $35 each. Tickets for all SMA-sponsored events may be purchased at the registration desks.

A golf tournament is scheduled for Sunday at the Capital City Country Club. A "fun run" is set for Sunday morning, and a tennis tournament is planned for Monday. Pre-registration forms for golf and tennis may be found in the SMA preliminary program. Sunday evening is reserved for receptions and dinners for the alumni of some 16 medical schools.

Spouse's Program

The Auxiliary of the MAG and the SMA have coordinated the planning of a variety of activities, including courses on "cocktail cooking," self-defense for women, calligraphy, fashion, and many other topics.

A tour of Peachtree Street, visits to Stone Mountain Park and the Cyclorama, plus an excursion to the antebellum homes of Covington are planned throughout the weekend.

Planning Committee

The MAG Committee on Scientific Assembly has cooperated with the SMA Committee on Scientific Work to make possible this second conjoint Scientific Assembly. Members of the MAG Committee are: C. Rex Teeslink, M.D., Chairman; C. Daniel Cabaniss, M.D.; Edwin C. Evans, M.D.; Eugene O. Harrison, M.D.; Ellis B. Keener, M.D.; Arthur J. Merrill, Jr., M.D.; Louis W. Sullivan, M.D.; and A. Calhoun Witham, M.D.

MAG Program Chairmen

The selection of speakers and topics for the scientific sessions meant hard work for program chairmen of the various state specialty societies. Special thanks go to:

Allergy and Immunology Society of Georgia, STANLEY M. FINEMAN, M.D.
Georgia Thoracic Society, JONNE B. WALTER, M.D.
Georgia Chapter, American College of Chest Physicians, A. FREDERICK BLOODWORTH, M.D.
Atlanta Dermatological Society, HENRY EARL JONES, M.D.
Georgia Chapter, American College of Emergency Physicians, MARK M. LINDSEY, M.D.
Georgia Academy of Family Physicians, TERRELL B. TANNER, M.D.
Georgia Gastroenterological Society, RONALD R. FAGIN, M.D.
Georgia State Obstetrical-Gynecological Society, DONALD L. BRANYON, JR., M.D.
Georgia Chapter, American College of Physicians, MALCOLM I. PAGE, M.D.
Georgia Society of Internal Medicine, MILTON FRANK, III, M.D.
Georgia Neurological Society, MARK A. KOZINN, M.D.
Georgia Neurosurgical Society, J. PETER REITT, M.D.
Georgia Psychiatry Association, ROBERT M. KOLODNER, M.D.
Georgia Orthopaedic Society, WILLIAM C. COLLINS, M.D.
Georgia Society of Otolaryngology, ALBERT A. CLAIRMONT, JR., M.D.
Georgia Association of Pathologists, CHRISTOPHER J. ALLAN, M.D.
Atlanta Society of Pathologists, CHARLES WHITAKER SEWELL, M.D.
Georgia Chapter, American Academy of Pediatrics, CHARLES W. LINDER, M.D.
Georgia Society of Plastic Surgeons, JOHN H. HARTLEY, JR., M.D.
Georgia Radiological Society, FRANK O. UNDERWOOD, M.D.
Georgia Chapter, American College of Surgeons, EUGENE D. DAVIDSON, M.D.

Summary of the Preliminary Program SMA-MAG Scientific Assembly

ALLERGY

Sunday Afternoon

SMA Section Secretary: JERALD M. DUNCAN, M.D., Memphis, TN.

Program Chairman — Allergy and Immunology Society of Georgia: STANLEY M. FINEMAN, M.D., Marietta

Guest Speaker: PHILLIP L. LIEBERMAN, M.D, Memphis, TN: **Radiocontrast Media Reactions** and **Allergic Emergencies.**

Papers will be presented on the following topics:

Effects of Extract Blotting on the Validity of the Multi-test, Michael S. Blaiss, M.D., and Heinz J. Wittig, M.D., New Orleans, LA

Diagnosis and Treatment of Hymenoptera Hypersensitivity, Rufus E. Lee, M.D., Dothan, AL

Immediate Hypersensitivity: Releasability of Mediators and Infectious Agents, Thomas F. Smith, M.D., Atlanta, GA

ANESTHESIOLOGY

Saturday morning and Sunday morning

SMA Section Secretary: RICHARD G. ZEPERNICK, M.D., New Orleans, LA

Guest Speaker: JOSEPH S. REDDING, M.D., Charleston, SC: **Resuscitation — Lost and Found.**

Papers will be presented on the following topics:

Single Shot Epidural Injection of Bupivicaine and Etidocaine: A Double Blind Comparison, A. H. Santora, M.D., and B. T. Finucane, M.D., Atlanta, GA

Isoflurane Anesthesia for the Pediatric Patient with Pheochromocytoma, John G. Morrow, III, M.D., and James W. Bland, Jr., M.D., Athens, GA

LTA Versus IV Lidocaine Prior to Intubation: Comparison of Hemodynamic Response and Blood Levels, John A. Youngberg, M.D., New Orleans, LA

Complications of Arterial Lines, Charles H. McLeskey, M.D., Winston-Salem, NC

Interscalene Approach to the Brachial Plexus: Paresthesia Versus Nerve Stimulator, Deborah McClain, M.D., and B. T. Finucane, M.D., Atlanta, GA

Electrical Hazards, Peter L. Hendricks, M.D., Birmingham, AL

Treatment of Refractory Ventricular Fibrillation with Bretylium Tosylate Following Cardiopulmonary Bypass, A. H. Santora, M.D., and B. T. Finucane, M.D., Atlanta, GA

Anesthetic Management of Atrial Septal Defect in the Adult, C. T. Ton, M.D., S. T. Hanowell, M.D., Y. D. Kim, M.D., S. Jelenich, M.D., and T. E. MacNamara, M.D., Bethesda, MD

The Use of Midazolam for Intramuscular Premedication, Ronald Vinik, M.D., and Jerry Reves, M.D., Birmingham, AL

Facts and Misconceptions Concerning Nitrous Oxide, Robert Sundin, M.D., John Adriani, M.D., and John Butler, M.D., New Orleans, LA

Cerebral Aneurysm in Pregnancy: Anesthetic Management, William J. Granger, M.D., and Robert D. McKay, M.D., Birmingham, AL

CHEST DISEASES

Saturday and Monday afternoon

SMA Section Secretary: BASHIR A. CHAUDHARY, M.D., Augusta, GA

Program Chairman — Georgia Thoracic Society: JONNE B. WALTER, M.D., Atlanta

Program Chairman — Georgia Chapter, American College of Chest Physicians: A. FREDERICK BLOODWORTH, M.D., Gainesville, GA

Guest Speaker: NAUSHER K. BURKI, M.D., Lexington, KY: **Clinical Investigations of Ventilatory Abnormalities**

POSTER PRESENTATIONS will be made on Saturday afternoon, 4:30-5:00.

GEORGIA THORACIC SOCIETY MEETING: **COMPUTERIZED TOMOGRAPHY OF THE CHEST,** Monday, 2-5 p.m. Peter Sones, M.D.: **Mediastinum: Vascular Lesions, Esophageal Lesions** and Michael Bernardino, M.D.: **The Malignant Chest Disease: Staging Carcinoma of the Lung — Evaluating Metastases, Solitary Nodules and Pleural Lesions.** Case presentations by Roy Crispin, M.D. Panel discussants: Robert Ellison, M.D., Joseph

Miller, M.D., Murray Gilman, M.D.; James Somogii, M.D., and Craig Nielson, M.D. The financial assistance of Aerox Health Care Services is gratefully acknowledged.

Other papers will be presented on the following topics, Saturday

Evaluation of Cardiac Syncope: Case Studies, Abdulla M. Abdulla, M.D., Augusta, GA

Arrhythmias in the Coronary Care Unit, Laurence Watkins, M.D., Augusta, GA

Physiological Approach to Cardiac Pacing, Joseph W. Rubin, M.D., Augusta, GA

Patients at Risk of Sudden Cardiac Death: Identification and Management, Martin J. Frank, M.D., Augusta, GA

Sleep Apnea Syndromes, Bashir A. Chaudhary, M.D., Augusta, GA

Newer Bronchodilators, William A. Speir, M.D., Augusta, GA

New Concepts in Sarcoidosis, Stephen S. Lefrak, M.D., St. Louis, MO

The Combined Medical/Surgical Approach to the Cure of the Non-M Tuberculosis Mycobacterioses, H. Mac Vandiviere, M.D., Marcus Dillon, M.D., and Irene G. Melvin, M.D., Lexington, KY

COLON AND RECTAL SURGERY

Sunday afternoon and Monday morning

SMA Section Secretary: RAUL RAMOS, M.D., San Antonio, TX

Guest Speaker: BERTRAM A. PORTIN, M.D., Buffalo, NY: **Sex and the Ostomate**

Other papers will be presented on the following topics:

Anoplasty for the Immobile Anal Canal, Donald R. Butts, M.D., Houston, TX

Elemental Diet in Colon and Rectal Surgery, Howard D. Robertson, M.D., Ocean Springs, MS

Extent of Operations for Chron's Disease, E. Earl Pennington, M.D., Atlanta, GA

Endometriosis Involving the Large Bowel, Gene W. Slagle, M.D., Shreveport, LA

Incidents of Multiple Carcinomas in a Large Metropolitan Hospital, Wallace Bailey, M.D., Dallas, TX

Puborectalis Plication Sphincteroplasty, Emmet Ferguson, Jr., M.D., Jacksonville, FL

Surgical Wound Infections, Robert E. Condon, M.D., Milwaukee, WI

DERMATOLOGY

Sunday morning, Monday, and Tuesday morning

SMA Section Secretary: KENNETH E. GREER, M.D., Charlottesville, VA

Program Chairman — Atlanta Dermatological Society: HENRY EARL JONES, M.D., Atlanta, GA

Guest Speaker: ROBERT E. JORDON, M.D., Milwaukee, WI: **Subepidermal Blistering Diseases**

Clinical Session at Emory University Medical Center, Sunday morning 9:00-12:00 noon, sponsored by the Atlanta Dermatological Society. A fee of $35 will be charged participants who are not either members or guests of the Atlanta Dermatological Society, presenters of cases for the Clinical Session, or dermatology residents. Bus transportation will be provided.

BURKS — Cooper Clinicopathologic Seminar, Monday morning.

Papers will be presented Monday afternoon and Tuesday morning on the following topics (partial list):

Hypocomplementemic Urticarial Vasculitis: Treatment with Dapsone, Fortunata Mendoza, M.D., Little Rock, AR

Acute Cutaneous Lupus Erythematosus Simulating Toxic Epidermal Necrolysis, Lynn Roberts, M.D., and James N. Gilliam, M.D., Dallas, TX

Cutaneous Lupus Erythematosus, Hashimoto's Thyroiditis, and Vitiligo, Jeffrey P. Callen, M.D., Louisville, KY

Hyperglobulinemic Purpura Presenting as Cutaneous Leukocytoclastic Vasculitis, Charles P. Hudson, M.D., and Jeffrey P. Callen, M.D., Louisville, KY

Dyskeratosis Congenita Presenting as Aplastic Anemia, Robert A. Swerlick, M.D., Barbara L. Braunstein, M.D., and Kenneth E. Greer, M.D., Charlottesville, VA

Squamous Cell Carcinoma of the Penis, Paul S. Collins, M.D., George A. Farber, M.D., and Andrew M. Hegre, M.D., New Orleans, LA

Epithelioid Sarcoma: A Case Report and Review, Theodore Rosen, M.D., Houston, TX

Verrucous and Hyperkeratotic Mycosis Fungoides, George P. Lupton, M.D., Marshall Guill, M.D., and Dolatria Naik, M.D., Fort Jackson, SC

Histiocytosis X: A Diagnostic Approach, James S. Storer, M.D., Herbert B. Christianson, M.D., and William J. Perret, M.D., New Orleans, LA

Gram-Negative Toe Web Infection, N. Fred

Eaglstein, M.D., and Wayne M. Marley, M.D., Memphis, TN

Gram-Negative Acne Requiring Hospitalization, John P. Kinney, M.D., West Palm Beach, FL

Basal Cell Cancers of the Skin as a Post Radiation Complication, J. Richard Allison, M.D., Columbia, SC

An Approach to the Abnormal Nail: Therapeutic Considerations, C. Ralph Daniel, M.D., Jackson, MS

Psoriasis-like Lesions Associated with Metroprolol Therapy, Imelda R. Mabrie, M.D., and Michael D. Tharp, M.D., Dallas, TX

Polyclonal Antigens in the Treatment of Dermatologic Disorders, Clyde N. Morgan, M.D., Abilene, TX

EMERGENCY MEDICINE

Saturday afternoon, Sunday morning, and Monday

SMA Section Secretary and Program Chairman — Georgia Chapter, American College of Emergency Physicians: MARK M. LINDSEY, M.D., Marietta, GA

Guest Speaker: BLAINE C. WHITE, M.D., Detroit, **Cerebral Resuscitation**

POSTGRADUATE COURSE on Venomous Bites: Snakes, Scorpions, and Spiders, Saturday afternoon. Fee for members of either association: $45; for nonmembers: $67.50 (Course G7).

Other papers will be presented on the following topics:

Gastric Volvulus in Children and **Central Anticholinergic Syndrome in Children,** Michel Dagher, M.D., Jacksonville, FL

Experience with a Multidisciplinary Emergency Medicine Clerkship, Kimball I. Maull, M.D., and Barry Yarborough, M.D., Richmond, VA

Emergency Department Management of Pain, Richard Y. McConnell, M.D., New Orleans, LA

Endotrachael Drug Administration, Michael I. Greenberg, M.D., Philadelphia, PA

FAMILY PRACTICE

Monday

SMA Section Secretary: W. ROSS LAWLER, M.D., San Antonio, TX

Program Chairman — Ga. Academy of Family Physicians: TERRELL B. TANNER, M.D., Oxford, GA

Papers will be presented on the following topics:

Current Therapy of Parkinson's Disease, Maureen M. Aaron, M.D., Winston-Salem, NC

Post Traumatic Epilepsy — When and How Long to Treat It, Alan Lambert, M.D., Houston, TX

Simple Febrile Convulsions Made Simple, Michael H. Link, M.D., Pensacola, FL

Hypertension in the Elderly and Mild Hypertension, William E. St. Clair, M.D., Houston, TX

Clinical Pearls in Urological Disease, George W. Shannon, M.D., Jackson, TN

Scoliosis, G. Jan Hinnen, M.D., Fort Gordon, GA

Valium: When Is It Indicated? Robert D. Armstrong, M.D., Fort Gordon, GA

GASTROENTEROLOGY

Sunday afternoon and Monday

SMA Section Secretary: CHESLEY HINES, JR., M.D., New Orleans, LA

Program Chairman — Georgia Gastroenterologic Society: RONALD R. FAGIN, M.D., Savannah, GA

Guest Speaker: JOHN T. SESSIONS, JR., M.D., Chapel Hill, NC: **New Developments in the Etiology and Treatment of Inflammatory Bowel Disease**

POSTGRADUATE COURSE on Colonic Disorders: Clinical Update for the Primary Care Physician, Sunday afternoon. Fee for members of either association: $45; for nonmembers: $67.50 (Course G12).

GASTROENTEROLOGY — COLON AND RECTAL SURGERY — RADIOLOGY — SURGERY JOINT MEETING, Monday afternoon: **Gastrointestinal Hemorrhages**

Other papers will be presented on the following topics:

Ascitic Fluid Lactate: A Preliminary Report, James L. Achord, M.D., and Barney Guyton, M.D., Jackson, MS

Campylobacter Enterocolitis in New Orleans, K. Gordon, M.D., Atilla Ertan, M.D., Ailleen Janney, Ph.D., A. Cook, M.D., F. Mather, M.D., and Kemal Akdamar, M.D., New Orleans, LA

Strongyloides Stercoralis Infestation in Upper East Tennessee, K. R. Reddy, M.D., and Eapen Thomas, M.D., Johnson City, TN

Ciguatera Fish Poisoning: Report of Three Cases, Ralph P. Pearce, M.D., Theodore W. Burns, M.D., Charles W. Clark, M.D., and Chesley Hines, Jr., M.D., New Orleans, LA

Barrett's Esophagus: An Analysis of Eighteen Cases, Charles Lackey, M.D., and Jack D. Welsh, M.D., Oklahoma City, OK

Gastric Lesions Induced by Potassium Supplementation: Comparison of Two Contrasting Formulations, F. Gilbert McMahon, M.D., Jerome R. Ryan, M.D., Kemal Akdamar, M.D., and Atilla Ertan, M.D., New Orleans, LA

Transendoscopic Needle Aspiration Cytology — A Comparison With Brush Cytology, Jeffrey B. Raskin, M.D., Sidney Neimark, M.D., Harold Rosen, M.D., and Mehrdad Nadji, M.D., Miami, FL

Ultrasonic Guided Liver Biopsy and Fine Needle Aspiration in Difficult Cases, Morteza Elyaderani, M.D., and Orlando Gabriele, M.D., Morgantown, WV

Small Bowel Ulceration and Stricture in Celiac Disease, Steve Venturatos, M.D., John Blalock, M.D., and Chesley Hines, Jr., M.D., New Orleans, LA

The Spectrum of Liver Disease in Hemophilia, Philip Blatt, M.D., Gilbert White, M.D., and Henry Lessesne, M.D., Chapel Hill, NC

INTERNAL MEDICINE

Saturday and Sunday morning

SMA Section Secretary: GEORGE A. PANKEY, M.D., New Orleans, LA

Program Chairman — Georgia Chapter, American College of Physicians: MALCOLM I. PAGE, M.D., Augusta, GA

Program Chairman — Georgia Society of Internal Medicine: MILTON FRANK, III, M.D., Atlanta, GA

ANNUAL LUNCHEON, GEORGIA SOCIETY OF INTERNAL MEDICINE, Sunday, 12-1:30 p.m. Spencer Meignan, M.D., Portland, OR, will speak on "Medicine in the Year 2000." Tickets will be mailed to GSIM members and will be on sale at the SMA-MAG registration desk.

Papers will be presented on the following topics:

Special Presentation — Hepatitis Update, John W. King, M.D., Shreveport, LA

The Prevalence of Reduced 3, 5, 3'-Triiodothyronine Production in the Stable Diabetic Clinic Population, C. S. Pittman, M.D., Jorge A. Pino, M.D., and B. R. Boshell, M.D., Birmingham, AL

The First Comprehensive Statewide Arthritis Plan, John L. McCain, M.D., and Charles A. Cook, M.D., Raleigh, NC

Long-term Effectiveness of Oncology Programs, Edwin C. Barnes, M.A., Phillip A. Desimone, M.D., Marilyn H. Appel, Ed.D., and Judith Mausner, M.D., Lexington, KY

Special Presentation — The Use and Abuse of the New Cephalosporins and Penicillins, Malcolm T. Foster, Jr., M.D., Jacksonville, FL

Special Presentation — Use of Calcium Channel-Blocking Agents in Clinical Practice, Martin J. Frank, M.D., Augusta, GA

Effective New Beta-Lactam Antibiotics in the Treatment of Gonorrhea, Brobson Lutz, M.D., William Mogabgab, M.D., Bruce Pauling, M.D., and Rose Beville, M.D., New Orleans, LA

The Diagnosis and Therapy of Splenic Abscess, Michael C. Tooke, M.D., New Orleans, LA

Reversal of Hypotensive Effect of High Dose Bethanidine with Tricyclic Protriptyline, Robert E. Keenan, M.D., J. H. Brinkerhoff, M.S., and E. M. Morley, M.D., Richmond, VA

Acute and Chronic Adrenal Insufficiency as a Result of Heparin Therapy, William W. Winternitz, M.D., Tuscaloosa, AL

Behcet's Disease — The Ochsner Experience, O. Thomas Feagen, M.D., New Orleans, LA

Special Presentation — The Diagnosis and Therapy of Atypical Pneumonia, Burke A. Cunha, M.D., Mineola, NY

Quantitative Decision Analysis, Rene E. Cormier, M.D., Augusta, GA

NEUROLOGY/NEUROSURGERY/ PSYCHIATRY

Saturday, Sunday, Monday morning, and Tuesday morning

SMA Section Secretary: WILLIAM L. MADEN, M.D., Johnson City, TN

Program Chairman — Georgia Neurological Society: MARK A. KOZINN, M.D., East Point, GA

Program Chairman — Georgia Neurosurgical Society: J. PETER REITT, M.D., Atlanta, GA

Program Chairman — Georgia Psychiatric Association: ROBERT M. KOLODNER, M.D., Decatur, GA

Guest Speaker: EWALD L. BUSSE, M.D., Durham, NC: **Biological Age Change and Impact on Behavior**

The Georgia Neurological Society and Georgia Neurosurgical Society will offer a conjoint meeting on Saturday. Speaking on **Brain Tumors — Complications and Treatment** will be Jerome Posner, M.D., Ithaca, NY, Abdel Ragab, M.D., Atlanta; Warner Ray, M.D., Atlanta; and Michael Saleman, M.D., Baltimore, M.D.

The Georgia Psychiatric Association has arranged for papers to be presented on Saturday on the following subjects: **A Personal View of Somatization Disorder (Briquet's Syndrome),** James R. Morrison, M.D., La Mesa, CA; **Depression in Children with Chronic Illness,** Eugene L. Crews, III, M.D., Smyrna, GA; and **Models of Mental Health Training for Primary Care and Their Relevance to Psychosomatic Medicine,** James J. Strain, M.D., New York, NY. The financial assistance of Lederle Laboratories and the Upjohn Company is gratefully acknowledged.

POSTGRADUATE COURSE on Psychiatry for the Primary Care Physician, Monday afternoon and Tuesday morning. Fee for members of either association: $90; for nonmembers: $135 (Course G19).

POSTGRADUATE COURSE on Neurology, Monday morning. Fee for members of either association: $45; for nonmembers: $67.50 (Course G13).

Other papers will be presented on the following topics, Sunday morning and Monday morning:

The Treatment of Psychotic Depression with Loxapine: A Neuroleptic with Antidepressant Metabolites, Earl A. Burch, Jr., M.D., and Thomas J. Goldschmidt, M.D., Columbia, SC

Neuropsychoendocrinology of Pregnancy, Leopold Hofstatter, M.D., St. Louis, MO

Chronic Intractable Hiccoughs, A Biopsychosocial Paradigm, B. William Freund, M.D., and Sreeja Kadakkal, M.D., Norfolk, VA

Stroke Risk Factors: Opportunities for Prevention, Bruce S. Schoenberg, M.D., Bethesda, M.D.

Ranking Therapeutic Modalities in an Adolescent Therapeutic Community, Victor R. Gonzalez, M.D., Smyrna, GA

The Religious Lives of Schizophrenics, William P. Wilson, M.D., and David B. Larson, M.D., Durham, NC

The Novalescent Mental Health Administrator: Remarks on the Confluence of Clinical Psychiatry and Psychiatric Administration; Remarks on the Dynamics of an Administrator-Led Graduate Group at Patient Conference, Jess V. Cohn, M.D., Boca Raton, FL

Recognition of Cognitive Impairment in Primary Care Outpatients, Thomas J. Goldschmidt, M.D., Robert Mallin, M.D., and Charles N. Still, M.D., Columbia, SC

Late-Onset Variant of Huntington's Chorea, Edward Faught, M.D., Birmingham, AL

The Practical Use of Neurotransmitters in a Psychiatric Hospital, Morgan E. Scott, M.D., Radford, VA

The Use of Community Participation as a Therapeutic Tool in Private Psychiatric Practice, Nicholas Ionedes, M.D., Washington, D.C.

OBSTETRICS AND GYNECOLOGY

Saturday, Sunday, Monday, and Tuesday morning

SMA Secretary (Obstetrics): R. HANK JENNINGS, M.D., Lakeland, FL

SMA Section Secretary (Gynecology): WILLIAM H. HENDERSON, M.D., Oxford,MS

Program Chairman — Georgia State Obstetrical/Gynecological Society: DONALD L. BRANYON, JR., M.D., Athens, GA

Guest Speaker (Gynecology): JOHN L. MARLOW, M.D., Washington, D.C.: **Laser Surgery in Gynecology**

Guest Speaker (Obstetrics): MARTIN PERNOLL, M.D., New Orleans, LA

POSTGRADUATE COURSE on Gynecologic Oncology for the Practicing Physician, Saturday. Fee for members of either association: $90; for nonmembers: $135 (Course G5).

POSTGRADUATE COURSE on Modern Trends in Gynecology, Sunday. Fee for members of either association: $90; for nonmembers: $135 (Course G10).

40th Annual Meeting, Southern Gynecological and Obstetrical Society, Monday morning

PAPANICOLAOU SEMINAR in Gynecologic Pathology, Tuesday morning

Papers will be presented on the following topics:

A Retrospective Epidemiologic Study of Vulvar Dystrophy, Robert M. Patterson, M.D., and Tim E. Field, M.D., Temple, TX

Diagnosis and Management of Vulvar Intraepithelial Neoplasia, Herbert W. Birch, M.D., Atlanta, GA

Microsurgical Placement of Gelfoam, Gelfilm, and Peritoneal Grafts: A Comparison of Reactivity, Joseph S. Sanfilippo, M.D., Robert J. Cosentino, M.D., and George H. Barrows, M.D., Louisville, KY

Ovarian Masses in the Child and Adolescent, Steve Golladay, M.D., and Daniel L. Mollitt, M.D., Little Rock, AR

Primary Surgery with Selective Postoperative Radiotherapy in Stage I Endometrial Carcinoma, John G. Phillips, M.D., Hugh M. Shingleton, M.D., James W. Orr, Jr., M.D., J. Max Austin, Jr., M.D., Kenneth D. Hatch, M.D., and Seng-Jaw Soong, Ph.D., Birmingham, AL

Acute Abdomen in Women on Continuous Anticoagulant Therapy, John G. Ricketson, M.D., and Shiraz H. Kassam, M.D., Augusta, GA

A Mind-Twisting Diagnosis — Adnexal Torsion, Tony Haskins, M.D., and Bob L. Shull, M.D., Temple, TX

Small Bowel Obstruction and Previous Gynecologic Surgery, John B. Ratcliff, M.D., and Peter S. Kapernick, M.D., Shreveport, LA

Status of the Cervix in Post-dates Pregnancy, Bruce Harris, M.D., and John F. Huddleston, M.D., Birmingham, AL

Cesarean Hysterectomy at LSU, 1976-1981, Warren C. Plauche, M.D., Michael Ianessa, M.D., Jacqueline Wycheck, M.D., Kirk Rousset, M.D., New Orleans, LA

Cancer of the Colon in Pregnancy, Joseph A. Hill, M.D., Shiraz H. Kassam, M.D., and O. Eduardo Talledo, M.D., Augusta, GA

OPHTHALMOLOGY

Saturday afternoon

SMA Section Secretary: JOHN F. NOWELL, M.D., Arlington, VA

POSTGRADUATE COURSE on Ophthalmology for the Non-Ophthalmologist, Saturday afternoon. Fee for members of either association: $45; for nonmembers: $67.50 (Course G8).

ORTHOPAEDIC SURGERY

Sunday, Monday, and Tuesday morning

SMA Section Secretary: ANGUS M. McBRYDE, JR., M.D., Charlotte, NC

Program Chairman — Georgia Orthopaedic Society: WILLIAM C. COLLINS, M.D., Atlanta, GA

Guest Speaker: DAVID HUNGERFORD, M.D., Baltimore, MD: **Early Diagnosis as a Means of Saving the Femoral Head in Avascular Necrosis** and **Total Knee Replacement — To Cement or Not To Cement? — That Is the Question**

A CLINICAL SESSION has been arranged by the Georgia Orthopaedic Society, Tuesday. Instruction will take place at the Scottish Rite Hospital for Crippled Children and the Shepherd Spinal Center. Transportation and luncheon arrangements will be available.

A KNEE SYMPOSIUM is scheduled for Sunday afternoon, and a SHOULDER SYMPOSIUM for Monday afternoon.

Other papers will be presented on the following topics:

Transchondral Talar Dome Fractures — Not Just a Sprained Ankle, William C. Nash, M.D., Fort Sam Houston, TX

Some Selected Uses of Flexible Medullary Rods in Femur Fractures, Paul B. Suh, M.D., and Paul H. Wright, M.D., Chapel Hill, NC

Surgical Management of Subtrochanteric Femoral Fractures, Jeffrey P. Rosen, M.D., Antenor Velazco, M.D., Lamar L. Fleming, M.D., and Thomas E. Whitesides, M.D., Atlanta, GA

The Management of Fractures of the Thumb Carpometacarpal Joint, J. Ollie Edmunds, M.D., New Orleans, LA

Electrical Stimulation of Osteogenesis: Review of Literature, Gary G. Poehling, M.D., and Herbert Haupt, M.D., Winston-Salem, NC

Total Hip Replacement in Renal Transplant Patients, Eric R. Oser, M.D., and Donald E. McCollum, M.D., Durham, NC

Walking Patterns in Total Knee Arthroplasty Patients, H. B. Skinner, M.D., M. Siegel, M.D., R. L. Barrack, M.D., S. D. Cook, M.D., and Ray J. Haddad, Jr., M.D., New Orleans, LA

Computerized Tomography in the Evaluation and Classification of Fractures of the Acetabulum, Rick K. St. Pierre, M.D., Thomas W. Oliver, M.D., James Somoygi, M.D., Howard Austin, M.D., and Lamar Fleming, M.D., Decatur, GA

Arthroscopic Lateral Retinacular Release of the Patella: A Preliminary Report, Richard L. Gaertner, M.D., Vienna, VA

Preoperative Skeletal Traction in Legg-Perthes Disease, John T. Killian, M.D., and Kurt M. Neimann, M.D., Birmingham, AL

Lateral Talocalcaneal Angle in Assessment of Subtalar Valgus: Followup of Seventy Grice-Green Arthrodeses, James Aronson, M.D., James Nunley, M.D., Durham, NC, and Karl Frankovitch, M.D., Erie, PA

One Stage Posteromedial (Subtalar) Release for Resistant Clubfeet, S. T. Canale, M.D., and Dennis M. Smith, M.D., Memphis, TN

Floating Knee Revisited, Steve Nichols, M.D., Robert Blake, M.D., and Angus M. McBryde, Jr., M.D., Charlotte, NC

Stevens-Johnson Syndrome Masking Staphylococcal Toxic Epidermal Necrolysis: A Case Report, William S. Ogden, M.D., José Estedez, M.D., and David Smith, P.A., Danville, VA

Abductor Paralysis and the Role of the External Oblique Transfer, Rick Hammesfahr, M.D., S. Topple, M.D., K. Yoo, M.D., T. Whitesides, M.D., and M. Paulin, M.D., Atlanta, GA

Cutting Tool Technology Applied to Arthroscopic Intra-Articular Surgical Instruments, W. H. Gondring, M.D., and C. R. Wheeler, M.D., St. Joseph, MO

Bone Biopsy: A Model for Wound Management, William W. Robertson, Jr., M.D., and Herbert F. Janssen, M.D., Lubbock, TX

Current Status of Porous Materials and Total Hip Arthroplasty, Emmett M. Lunceford, Jr., M.D., Columbia, SC

Segmental Spinal Instrumentation in the Management of Fractures of the Thoracolumbar Spine: A Preliminary Report, Thomas N. Bernard, Jr., M.D., Thomas S. Whitecloud, III, M.D., and Ray J. Haddad, Jr., M.D., New Orleans, LA

Arthrodesis of the Knee and Ankle with Hoffman External Fixation, Antenor Velazco, M.D., and Lamar L. Fleming, M.D., Atlanta, GA

OTOLARYNGOLOGY

Saturday, Sunday morning, and Monday morning

SMA Section Secretary: ROBERT F. TARPY, M.D., LaFayette, LA

Program Chairman — Georgia Society of Otolaryngology: ALBERT A. CLAIRMONT, M.D., Atlanta, GA

Guest Speaker: A. PAUL KELLER, JR., M.D., Athens, GA: **Otolaryngology — Head and Neck Surgery: A Retrospective and Prospective View of the Specialty**

POSTGRADUATE COURSE on Evaluation and Treatment of the Patient with Dizziness, Saturday afternoon. Fee for members of either association: $45; for nonmembers: $67.50 (Course G9).

Papers will be presented on the following topics:

Repair of Traumatic Nasal Collapse When Septal Cartilage Is Not Available, William E. Silver, M.D., Atlanta, GA

Surgical Management of Zygomatic Fractures, Keith L. Kreutziger, M.D., New Orleans, LA

The Use of CO_2 Laser in Otolaryngology — Head and Neck Surgery, Romeo Y. Lim, M.D., Charleston, WV

Peritonsillar Abscess — To Operate or Not, G. Richard Holt, M.D., San Antonio, TX

Revision Surgery in Patients with Previous Stapedectomy, Tympanoplasty, and Mastoidectomy, John S. Turner, Jr., M.D., Atlanta, GA

The Flaccid Tympanic Membrane: Technique for Repair, Donald N. Matheson, M.D., Fort Worth, TX

Correction of the Asymmetrical or Twisted Bony Nasal Pyramid, Daniel M. Adams, III, M.D., East Point, GA

Modifications of the Classical Radical Neck Dissection, Albert A. Clairmont, M.D., and John Teichgraeber, M.D., Atlanta, GA

Combined Extracranial-Intracranial Approaches to Skull Base Tumors, J. David Osguthorpe, M.D., Charleston, SC

Occult Metastasis from Oral Cancer, John Teichgraeber, M.D., and Albert A. Clairmont, M.D., Atlanta, GA

Panendoscopy — A Necessity in the Work Up of the Head and Neck Cancer Patient, W. Fred McGuirt, M.D., Winston-Salem, NC

Consequences of Parotidectomy, Mike Powell, M.D., Lilburn, GA, and Albert A. Clairmont, M.D., Atlanta, GA

Local Anesthesia for Major Head and Neck Surgery, W. J. Grist, M.D., T. E. Nix, M.D., and M. P. Peters, M.D., Atlanta, GA

Mandibular Osteotomy Approaching Cancer of the Oral Cavity, Fred M. S. McConnel, M.D., and John Teichgraeber, M.D., Atlanta, GA

Orbital Exenteration Due to Basal Cell Carcinoma, Peter Suhge D'Aubermont, M.D., Richard G. Bennett, M.D., and Fred M. S. McConnel, M.D., Atlanta, GA

The Use of Corticosteroids in the Management of Allergic Rhinitis, Richard L. Mabry, M.D., Dallas, TX

Relief of Nocturnal Angina and Tinnitus by Food Therapy, Stanley J. Cannon, M.D., Miami, FL

Incus Replacement with Goblet Prosthesis in Ossicular Chain Reconstruction, Dennis G. Pappas, M.D., Birmingham, AL

Blastomycosis of the Larynx, Michael Dunham, M.D., and Robert B. Butcher, II, M.D., New Orleans, LA

PATHOLOGY

Saturday, Sunday, Monday, and Tuesday morning

SMA Section Secretary: C. FENNER McCONNELL, M.D., Pensacola, FL

Program Chairman — Georgia Association of Pathologists: CHRISTOPHER J. ALLAN, M.D., Atlanta

Program Chairman — Atlanta Society of Pathologists: CHARLES WHITAKER SEWELL, M.D., Atlanta

Guest Speaker: FRANK VELLIOS, M.D., Atlanta: **Obstetrics/Gynecology Topic — Uterine Sarcomas**

ANNUAL SLIDE SEMINAR — Atlanta Society of Pathologists, Sunday: Joseph M. Mirra, M.D., Los Angeles, CA: **Tumors of Bone and Soft Tissue.** Slide set: $35. A fee of $10 will be charged attendees who do not purchase slides.

BURKS-COOPER CLINICOPATHOLOGIC SEMINAR, Monday morning.

PAPANICOLAOU SEMINAR in Gynecologic Pathology, Tuesday morning.

Papers will be presented on the following topics on Saturday and Monday afternoon (partial list):

Prostatic Adenocarcinoma Metastasizing as a Signet Ring Carcinoma, Jerry D. Porter, M.D., and David Stacy, M.D., Atlanta, GA

Dural Metastatic Neoplasia: A Rare Cause of Subdural Hematoma, Jesse R. Stafford, M.D., Mobile, AL

Metastatic Carcinoma of Breast in Pyriform Sinus, Cam Nguyen, M.D., and Stanley Weitzner, M.D., Houston, TX

Perilobular Hemangioma of Breast, Stanley Weitzner, M.D., Houston, TX

Brucellosis Causing Hepatic Granuloma, Eric P. Ellington, M.D., Atlanta, GA

Granular Cell Tumor of the Common Bile Duct, J. Paul Hughes, M.D., and Bhagirath Majmudar, M.D., Atlanta, GA

Multicentric, Smooth Muscle Neoplasm of the Stomach and Small Intestine (Leiomyomatosis Superficialis Disseminata), C. Fenner McConnell, M.D., and Dewey Torres, M.D., Pensacola, FL

Forensic Aspects of Drug-Related Deaths, James K. Metcalfe, M.D., Dalton, GA

Krukenberg Tumors of the Ovary, Bhagirath Majmudar, M.D., Atlanta, GA

The Unusual Concurrence of Androblastoma in Pregnancy — Report of Three Cases, Elizabeth A. Manci, M.D., Mobile, AL

PEDIATRICS

Saturday, Sunday morning, and Monday

SMA Section Secretary: EDWARD G. GREEN, M.D., Charlotte, NC

Program Chairman — Georgia Chapter, American Academy of Pediatrics: CHARLES W. LINDER, M.D., Augusta, GA

Guest Speaker: SAMUEL L. KATZ, M.D., Durham, NC: Panel Discussion, **A Look at Ourselves — The Pediatrician and His Problems**

POSTGRADUATE COURSE on Pediatric Endocrinology, Monday morning. Fee for members of either association: $45; for nonmembers: $67.50 (Course G14).

POSTGRADUATE COURSE on Adolescent Sports Medicine, Monday afternoon. Fee for members of either association: $45; for nonmembers: $67.50 (Course G18).

Other papers will be presented on the following topics:

Clinical Neonatal Dermatology, Sami B. Elhassani, M.D., Spartanburg, SC

Hyperbilirubinemia and Phototherapy: An Update, Edward G. Karotkin, M.D., Norfolk, VA

Evaluation of Gastroesophageal Reflux, Margaret F. Guill, M.D., Tesneem K. Chaudary, M.D., and Betty B. Wray, M.D., Augusta, GA

Infant Screening Examination for Motor Delay, Jay Nogi, M.D., Alice Luck, R.P.T., and Beth Tolley, R.P.T., Richmond, VA

Sudden Infant Death Syndrome: A Community Hospital's Approach to Infant Home Monitoring, W. Scott James, M.D., Atlanta, GA

Otitis Media: A Review of Tympanography and Ventilation Tubes, Russell R. Lyle, M.D., Starkville, MS

Adolescent Sexuality: A Gynecologist's Viewpoint, William J. Wortman, Jr., M.D., Charlotte, NC

Alcoholic Beverage Consumption in Adolescents: The Disease and Its Prevention, William H. Armes, Jr., M.D., Rossville, TN

Intrafamilial Stress and the Pediatric Patient, Alanson Hinman, M.D., Winston-Salem, NC

PLASTIC SURGERY

Monday

SMA Section Secretary: GORDON S. LETTERMAN, M.D., Washington, D.C.

Program Chairman — Georgia Society of Plastic Surgeons: JOHN H. HARTLEY, JR., M.D., Atlanta

Guest Speaker: JOHN E. WOODS, M.D., Rochester, MN: **Subcutaneous Mastectomy: Indications, Risks, Results, and Complications** and **Management of Malignant Melanoma**

Other papers will be presented on the following topics:

Breast Reconstruction Using the Natural-Y Prosthesis, William E. Schatten, M.D., Atlanta, GA

The Meaning of Surgical Margins, Peter Suhge D'Aubermont, M.D., Richard D. Bennett, M.D., and Foad Nahai, M.D., Atlanta, GA

Preventing Postoperative Deformities with Submental Lipectomy and Rhytidectomy, John R. Royer, M.D., Winter Park, FL

Blepharoplasty: A Many Faceted Procedure, John R. Lewis, Jr., M.D., Atlanta, GA

Breast Reconstruction after Cancer Using the Transverse Abdominal Technique, Carl R. Hartrampf, Jr., M.D., Atlanta, GA

Cancer Care in a Korean Mission Hospital, David J. Seel, M.D., Korea, and Richard A. Heimburger, M.D., Columbia, MO

Computer Technology in Plastic Surgery — Nationwide Educational Network, Richard C. Mattison, M.D., Atlanta, GA

Reconstruction of Large Scalp Defects with Two-Dimensional Galeal Scoring and Primary Advancement, Steven D. Macht, M.D., Washington, D.C.

Medical Missions in the Orient: A Plastic Surgical Challenge, Richard A. Heimburger, M.D., Columbia, MO

An Evaluation of the Lotus Water Mattress in the Prevention of Pressure Sores, Kenna S. Given, M.D., C. Kelley, M.D., and D. Dillman, M.D., Augusta, GA

RADIOLOGY

Saturday, Sunday, and Monday morning

SMA Section Secretary: EDWARD I. BLUTH, M.D., New Orleans, LA

Program Chairman — Georgia Radiological Society: FRANK O. UNDERWOOD, M.D., Atlanta, GA

Guest Speaker: ROBERT ZIMMERMAN, M.D., Philadelphia, PA: **The Radiologic Approach to the Spine and Spinal Cord with CT and Myelography,** and **Medical Imaging in Neuroradiologic Diagnosis: Current and Future State**

Guest Speaker, Radiological Society of North America: RICHARD C. PFISTER, M.D., Boston, MA: **Interventional Uroradiology**

RADIOLOGY — UROLOGY JOINT MEETING, Sunday: **Interventional Uroradiology, Intraoperative Radiological Techniques, Renal Masses,** and **Testicular Masses.**

Other papers will be presented on the following topics:

Radiological Examination of the Small Intestine, Wilma C. Diner, M.D., Little Rock, AR

Investigation of the Retrogastric Mass with Computerized Tomography and Ultrasound, H. A. Munitz, M.D., D. J. Ott, M.D., N. T. Wolfman, M.D., and N. Karstaedt, M.D., Winston-Salem, NC

A New, Simple Non-Invasive Quantitative Method to Detect GI-GU Fistulae, Charles D. Teates, M.D., and Stuart S. Howards, M.D., Charlottesville, VA

Percutaneous Fine Needle Aspiration of Solid Masses with Ultrasonic Guidance, Morteza K. Elyaderani, M.D., Denise Kalinowski, M.D., J. Tehranzadeh, M.D., and Orlando F. Gabriele, M.D., Morgantown, WV

Pleural Mesothelioma, Bruce R. Baumgartner, M.D., and Gordon L. Hixson, Jr., M.D., Atlanta, GA

The Chest Radiograph and Rocky Mountain Spotted Fever, Robert H. Choplin, M.D., Winston-Salem, NC

Emergency Room Radiology: A Profile-Preliminary Experience with a Dedicated Emergency Room Radiographic System, Jesse T. Littleton, M.D., Mobile, AL

Lymphomas and Pseudolymphomas of the Orbit, D. Venkata Rao, M.D., and Karen Crosby, M.D., St. Louis, MO

Algorithmic Approach to Evaluation of the Temporomandibular Joint, Kenneth A. Bell, M.D., New Orleans, LA

The Radiographic Evaluation of the Blom-Singer Prosthesis for Vocal Restoration after Laryngectomy, T. L. Pope, Jr., M.D., H. A. Shaffer, Jr., M.D., M. E. Johns, M.D., R. W. Cantrell, M.D., and B. C. Woodson, M.D., Charlottesville, VA

Intramammary Lymph Nodes, Robert L. Egan, M.D., and Marjorie B. McSweeney, M.D., Atlanta, GA

Periosteal New Bone Formation of Adjacent Bone in Cases of Osteoid Osteoma and Benign Osteoblastoma, Issa Yaghmai, M.D., Richmond, VA

Computed Tomography of the Cervical Spine, C. Gene Coin, M.D., Fayetteville, NC

The Radiological Evaluation of Painful Total Hip Replacement, Jamshid Tehranzadeh, M.D., Robert Schneider, M.D. and Robert H. Frieberger, M.D., Morgantown, WV

The Nursing Coordinator in a Diagnostic Radiology Department, Alfred Schick, M.D., and Glenn Watkins, M.D., Clearwater, FL

ADDITIONAL CME for radiologists, though not a part of the SMA-MAG Scientific Assembly will be offered by the Department of Radiology, Emory University School of Medicine, in a course on **Chest Radiology,** October 29-30 at the Colony Square Hotel. Fee is $150. Contact the Director, Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH: 404/329-5696.

SURGERY

Sunday and Monday morning

SMA Section Secretary: KIRBY I. BLAND, M.D., Louisville, KY

Program Chairman — Georgia Chapter, American College of Surgeons: EUGENE D. DAVIDSON, M.D., Atlanta, GA

Guest Speaker: ROBERT E. CONDON, M.D., Milwaukee, WI: **Surgical Wound Infections**

POSTER PRESENTATIONS, Sunday morning and Monday morning.

Other papers will be presented on the following topics:

The Natural History of the Asymptomatic Carotid Bruit As Defined by the Vascular Laboratory, Charles E. Ingalls, M.D., and Howard C. Snider, M.D., Montgomery, AL

Pregnancy and Breast Cancer, Martin H. Max, M.D., and Thomas W. Klamer, M.D., Milwaukee, WI

Adenocarcinomas of Right and Transverse Colon, Michael J. Edwards, M.D., Donald E. Fry, M.D., and Philip J. Harbrecht, M.D., Louisville, KY

Detection of Asymptomatic Internal Carotid Artery Stenosis in Patients Undergoing Coronary Artery Surgery, B. A. Keagy, M.D., C. L. Lucas, M.D., D. D. Thomas, M.D., and J. W. Battaglini, M.D., Chapel Hill, NC

A Community Hospital's Experience with Transluminal Angioplasty — A Surgeon's Viewpoint, Thomas A. Gaskin, M.D., James H. Isobe, M.D., and James Ballard, M.D., Birmingham, AL

Diagnostic Radiation Exposure in Trauma Patients, R. Fitzgerald, M.D., H. D. Reines, M.D., and J. Wise, M.D., Charleston, SC

Abdominal Incisions: Comparison of the Transverse Versus the Vertical Placement; A Con-

tinuous Versus an Interrupted Closure, P. R. Strom, M.D., H. H. Stone, M.D., S. J. Hoefling, M.D., W. E. Dunlop, M.D., and T. C. Fabian, M.D., Atlanta, GA

Breast Necrosis Complicating Anticoagulation Therapy, C. Doyle Haynes, M.D., James W. Mathews, M.D., Nelson Gwaltney, M.D., and William D. Lazenby, M.D., Opelika, AL

Colostomy Closure: Morbidity Reduction Employing a Standardized Approach, R. K. Salley, M.D., R. M. Bucher, M.D., and C. B. Rodning, M.D., Mobile, AL

A Totally Implantable Drug Infusion Pump for Metastatic Colorectal Carcinoma to the Liver, Charles M. Balch, M.D., and Marshall M. Urist, M.D., Birmingham, AL

Thyroid Nodule: A More Specific, Cost Effective, Diagnostic Approach, G. L. Irvin, III, M.D., S. Pierce, M.D., E. G. Levy, M.D., and M. Nadji, M.D., Miami, FL

Phlegmasia Cerulea Dolens: Medical Versus Surgical Therapy, Peter Gloviczki, M.D., Larry H. Hollier, M.D., and Alexander Schirger, M.D., Rochester, MI

IPG as a Screening Device for Deep Vein Thrombosis, O. W. Brown, M.D., J. R. Navarre, M.D., and P. Clark, M.D., Southfield, MI

Combined Renal Artery and Aortic Reconstruction, A. Reif Kessler, M.D., William H. Edwards, M.D., and Joseph L. Mulherin, Jr., M.D., Nashville, TN

Surgical Treatment of Chronic Pancreatitis, Keith F. Brewer, M.D., and Herbert Proctor, M.D., Chapel Hill, NC

Perforated Gallbladders, William M. Rambo, M.D., Charleston, SC

Reassessment of Graham-Steel Closure in Acute Perforated Peptic Ulcer, Mary E. Fallat, M.D., Michael J. White, M.D., J. David Richardson, M.D., and Lewis M. Flint, M.D., Louisville, KY

Severe Systemic Sepsis Resulting from Neglected Perineal Infections, M. F. Adinolfi, M.D., D. C. Voros, M.D., N. M. Moustoukas, M.D., and Ronald L. Nichols, M.D., New Orleans, LA

Gallbladder Disease and Morbid Obesity, M. Theit, M.D., C. Herbst, Jr., M.D., and J. Buckwalter, M.D., Chapel Hill, NC

UROLOGY

Sunday and Monday

SMA Section Secretary: HAROLD A FUSELIER, M.D., New Orleans, LA

Guest Speaker: MARTIN I. RESNICK, M.D., Cleveland, OH. **Recent Progress in Ultrasonography of the Bladder and Prostate**

UROLOGY — RADIOLOGY JOINT MEETING, Sunday: **Interventional Uroradiology,** Richard C. Pfister, M.D., Boston, MA; **Intraoperative Radiological Techniques,** Martin I. Resnick, M.D., Cleveland, OH. Drs. Pfister and Resnick will also discuss urologic and radiologic aspects of renal masses and testicular masses.

Other brief papers will be presented on Monday morning.

HARRY SPENCE PYELOGRAM CONFERENCE, Monday afternoon.

OTHER POSTGRADUATE COURSES

Adult Respiratory Distress Syndrome, Saturday. Fee for members of either association: $90; for nonmembers: $135 (Course G6).

Cardiology Update, Saturday morning and Sunday morning. Fee for members of either association: $90; for nonmembers: $135 (Course G4).

Fluids and Electrolytes, Saturday morning. Fee for members of either association: $45; for nonmembers: $67.50 (Course G3).

Fundamentals of Contemporary Clinical Endocrinology, Sunday. Fee for members of either association: $90; for nonmembers: $135 (Course G11).

Infectious Diseases, Saturday morning. Fee for members of either association: $45; for nonmembers: $90 (Course G1).

Nutrition Fads, Monday morning. Fee for members of either association: $45; for nonmembers $67.50 (Course G17).

Practical Electrocardiography, Monday. Fee for members of either association: $90; for nonmembers: $135 (Course G16).

Recent Advances in Diabetes, Monday. Fee for members of either association: $90; for nonmembers: $135 (Course G15).

Rheumatology, Saturday morning. Fee for members of either association: $45; for nonmembers: $67.50 (Course G2)

SMA/MAG COURSE REGISTRATION

Please return to: Southern Medical Association
2601 Highland Avenue, PO Box 2446
Birmingham, Alabama 35201
Phone inquiries: (205) 323-4400

Please Note: The course registration fee for nonmember physicians is approximately 50% higher than the fee for SMA members. Medical Student members of the SMA and student nonmembers will be admitted to courses at no fee on a space available basis one hour prior to course sessions; however, nonmember medical students must pay a $15.00 gate fee. A 50% discount on course fees is given to retired physicians and physicians in postgraduate training years 1 through 6 based on current status as physician member or nonmember. Payment (made payable to SMA) must accompany choice of courses requested on this registration form.

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STATUS: 1. ☐ PHYSICIAN 2. ☐ RESIDENT 3. ☐ STUDENT
4. ☐ ALLIED HEALTH 5. ☐ OTHER

DATE	Course No.	Fee	Office Use Only Ticket No.

Course fees _____

TOTAL REMITTANCE _____

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_____MEETING SERVICES
_____SMA AUXILIARY
_____GUEST
OTHER_____

Is your spouse accompanying you to the Meeting? ☐ Yes ☐ No

☐ I hereby apply for membership in the Southern Medical Association and enclose $50 for my annual dues, which includes four percent for my JOURNAL subscription.

Make checks payable to Southern Medical Association

_____President's Luncheon—Monday $15.00 each $_____

_____President's Night Dinner Dance—Monday $35.00 each $_____

Total Remittance $_____

Refund Deadlines:
Luncheon refund deadline is 5:00 p.m., Sunday, October 31.
Dinner Dance refund deadline is 9:00 a.m., Monday, November 1.

Return to:
Southern Medical Association
2601 Highland Avenue
P.O. Box 2446
Birmingham, Alabama 35201
Telephone (205) 323-4400

Spouses' Program

Presented by the Auxiliary of the Southern Medical Association and the Medical Association of Georgia.

Seminars, tours, social gatherings, and business meetings are planned throughout the Scientific Assembly. The following is a summary of the Auxiliary Seminar schedule. For the complete program and registration information, please contact Mrs. Perry M. White, SMA Auxiliary Convention Chairman, 1547 Cave Rd., N.W., Atlanta 30327 (phone: 404/261-0880) or the SMA, 2601 Highland Ave., P.O. Box 2446, Birmingham, AL 35201 (phone: 205/323-4400).

SATURDAY, OCTOBER 30

Doctors Do Die — 10:30 am-12:00 noon
Authoress Marguerite E. Tracy, plus an attorney and a trust officer discuss estate planning. $8.50.

A Taste of the Peach — 11:00 am-4:30 pm
Tour Peachtree Street and shop at Lenox Square. Lunch is scheduled at Anthony's. $29.00.

The Magic of Silk Flowers — 2:00 pm-4:00 pm
Learn to make your own. $8.00

Cocktail Cooking — 2:00 pm-4:30 pm
Cookbook authoress Ursula demonstrates twelve cocktail buffet dishes. $17.50.

SUNDAY, OCTOBER 31

Self Defense For Women — 10:00-11:00 am
A professional safety officer will give practical tips and demonstrations on personal safety. $6.00.

Stone Mountain Park — 10:00 am-3:00 pm
The world's largest carving honoring Generals Lee and Jackson and President Davis is surrounded by acres of landscaped grounds and other attractions. A trip to the newly renovated Cyclorama, depicting the Battle of Atlanta, is also included. $29.75.

How To Say What You Really Feel — 2:00 pm-3:00 pm
Learn to express yourself with tact and diplomacy. $12.00.

The Fascinating Art of Calligraphy — 2:00 pm-4:00 pm
The art of beautiful handwriting will be demonstrated — a skill useful in preparing announcements and invitations. $12.50.

MONDAY, NOVEMBER 1

Color You Beautiful — 10:00 am-11:00 am
An expert in color analysis will demonstrate the best styles and makeup for your personal appearance. $10.00.

What the Wife Needs to Know About the Business Side of Her Husband's Practice — 10:00 am-12:00 noon
A speaker from a practice management firm is featured. $9.50.

Mansions and Magnolias — 2:00 pm-5:30 pm
Tour Covington, 35 miles east of Atlanta, with its historic homes. $18.00.

Focusing the Fashion Spotlight on You — 2:30 pm-3:30 pm
Marlene Cavanaugh, former Miss America finalist, speaks on choice of color and accessories. $7.50.

HOUSING INFORMATION
SMA-MAG'S SCIENTIFIC ASSEMBLY

Hotel	Single	Double/Twin	Suites
Peachtree Plaza	$74.00	$86.00	$195.00 and up
Hyatt Regency	$75.00	$85.00	$195.00 and up
Omni International	$79.00	$90.00	$210.00 and up

First night's deposit will be requested, if required, upon receipt of confirmation from hotel. Do not send checks to the Atlanta Housing Bureau.

(Detach here and mail directly to Housing Bureau.)

HOUSING ACCOMMODATION REQUEST FORM
SMA-MAG'S SCIENTIFIC ASSEMBLY
October 30-November 2, 1982

Print or Type

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Telephone (___) _____

SHARE WITH

Arrival Date_____ Time_____ a.m. p.m.

Departure Date _____

Type of Room_____ at $_____rate

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233 Peachtree Street, NE, Suite 200
Atlanta, Georgia 30043

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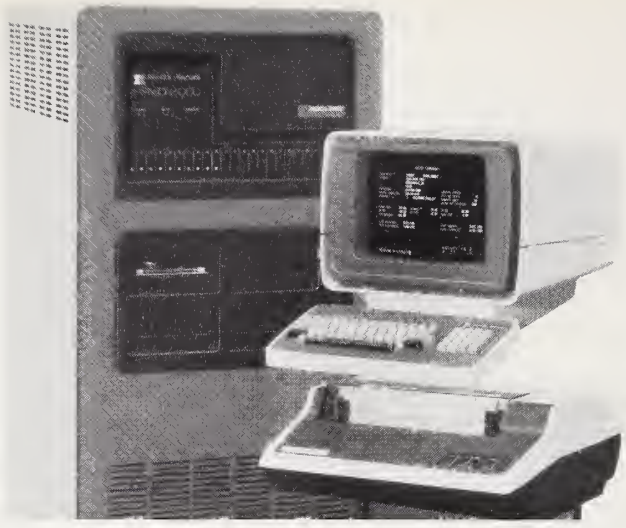
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THE COVER

A weekend of stimulating speakers and discussion on the hottest issues facing organized medicine today is scheduled for MAG's first Leadership Conference, Nov. 12-14, 1982, at Callaway Gardens. The program and speakers are presented in this issue of the *Journal,* along with an editorial by Dr. Charles D. Hollis, Jr. Observe how the MAG continues to take the initiative in serving the needs of Georgia physicians.

Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

New Program Underway to Reduce Illicit Drug Traffic in the Metro Atlanta Area

A new program aimed at reducing drug abuse and illicit drug traffic resulting from legally obtained prescription drugs began in the metro Atlanta area on July 4th. Developed jointly by the Medical Association of Atlanta (MAA) and the Georgia Pharmaceutical Association (GPhA), the program is aimed initially at amphetamine drugs.

Dr. William B. Anderson, chairman of the MAA alcohol and drug abuse committee, said the essential elements of the program are that physicians are being asked not to prescribe the drugs except for specific rare conditions; pharmacists are being asked not to stock the drugs in stores; any prescription written and presented to a pharmacy will be filled only after a 48-hour waiting period while the drugs are obtained from the wholesale supplier, and prescriptions will be written and filled only in full package quantities.

"It's a voluntary program because that's all the two associations can ask their members to do," Dr. Anderson explained. He said the program has been endorsed by local medical societies covering Fulton, Cobb, DeKalb, Gwinnett, Forsyth, Clayton, Fayette, and Douglas counties, as well as the MAA.

"Letters announcing the program and signed by the president of each of the societies were sent to more than 3,000 licensed medical doctors and osteopaths in the area," he said, "and this includes those physicians who are not members of any medical society."

Dr. Anderson said data compiled by the Drug Enforcement Administration show a volume of amphetamines being prescribed and dispensed in Atlanta that is "completely out of proportion to medical needs." He pointed out that the three conditions for which exceptions are made in the program — narcolepsy, hyperkinesis, and refractory depression — are relatively rare.

Jeff Lurey, R.Ph., spokesman for the GPhA, said that in addition to an interest in helping reduce the drug abuse problem, pharmacists are hopeful that by not stocking amphetamines, there will be fewer burglaries and robberies of pharmacies. Mr. Lurey said the 48-hour delay in filling prescriptions should not be an inconvenience to patients with legitimate medical needs.

"It will simply be a matter of the patient and the physician planning for the delay so a new prescription can be obtained before the supply of medicine on hand runs out. The 48-hour delay, on the other hand, will give pharmacists time to verify prescriptions with physicians, and this should be a big help in identifying forged or fraudulently obtained prescriptions," he said.

Dr. Anderson said the program initiated in Atlanta is patterned after the highly successful program developed by the Duval County (Jacksonville, FL) Medical Society 2 years ago. He said the July 4th starting date "is symbolic of our hope that through better public understanding of the extent and nature of the drug abuse problem, and through the cooperation of physicians and pharmacists, we can help a lot of people gain freedom from a dangerous drug habit. We are also concerned that many amphetamine drugs, obtained by prescription, find their way into illicit traffic and are sold to children. Our communities definitely deserve freedom from that kind of menace."

E.T. — EMC

Introduction

At the 1982 MAG Annual Session in Savannah, Prudential Medicare representatives were present to explain the features of Electronic Media Claims (EMC) processing and its importance to an efficient reimbursement of Medicare fees. The House of Delegates endorsed the concept of electronic submission of claims in 1981. The following information submitted by Charles S. Adams, Manager, Administrative Services, Prudential Medicare, explains the benefits of EMC, the available modes, and how you should proceed if you wish to learn more about EMC.

Keith Quarterman, M.D.
Medical Director
Prudential Medicare

Just as "E.T." is sweeping the movie-going community this summer, EMC is developing a growing level of interest and involvement in the medical community. Prudential, as the Medicare B Contractor in Georgia, has been actively developing this efficient alternative to paper claims processing over the past 18 months. All signs indicate that just like E.T., it is about to take off.

The benefits of EMC include:

- — significantly improved cash flow
- — provider control of customary profile
- — consistent quality of reimbursement
- — virtual elimination of status requests or requests for review
- — potential for automated accounting for Medicare accounts
- — receipt of patient account numbers on payment records
- — payment on a weekly basis rather than bi-weekly basis which is to be implemented for paper claims in late 1982.

Electronic Media Claim processing has four available modes:

COMPUTER-to-COMPUTER BILLING: telecommunications between Prudential's IBM 370/168 computer in Millville, N.J., and computers in physicians' offices, mediplexes, hospitals, or billing service offices in Georgia.

MAGNETIC TAPE & DISKETTES (floppy disks):

transportable computer storage media for computer systems not equipped with teleprocessing facilities.

PHYSICIAN DIRECT CLAIM ENTRY (PDCE): placement of Cathode Ray Tube (CRT) in physician's office which would be linked by telephone lines to Prudential's computer in New Jersey.

Currently, Prudential is receiving 4% (12,000 claims per month) of our Medicare claims via EMC with anticipated volume of 10% (30,000 claims per month) in 1983. EMC is useful for small providers with approximately 100-200 claims per month who use one of a number of computerized billing services and for the majority of intermediate (500 to 1,000 claims per month) medical practices and the large clinics (2,000 to 5,000 claims per month) who have their own computer systems.

How does a physician learn more about EMC? Contact Prudential Medicare at 404-325-5614, Ext. 253, and ask for Ms. Deane Richard, Mr. Ed Vinson, or Mr. Charles Adams; attend Medicare workshops; and talk with one of your peers who has successfully been using EMC with Prudential.

What does a physician need to do to participate in EMC? Contact Prudential Medicare, review the EMC information package, request the EMC NATIONAL STANDARD FORMAT specifications for your computer programmer or biller to review, request a list of EMC billing services or software firms interested in providing these services, and request a visit by our EMC experts, Ms. Richard and Mr. Vinson.

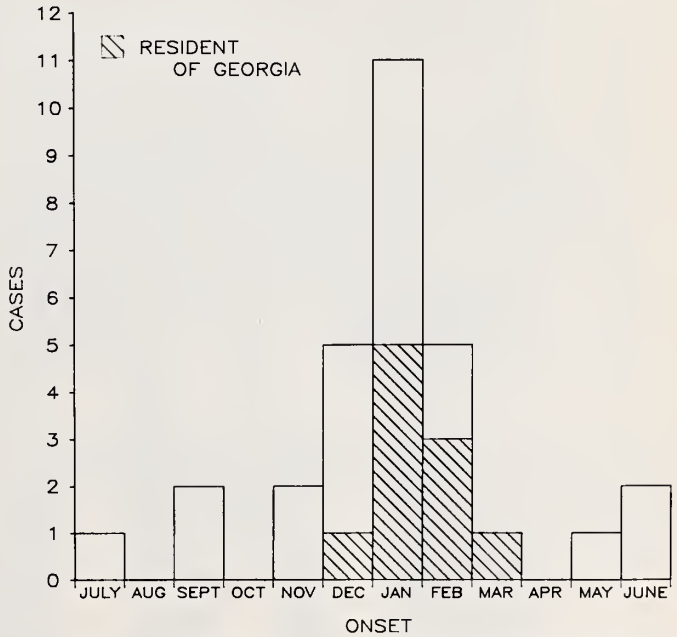
EMC may not be as entertaining as E.T.; however, it can be a very rewarding experience, one which will produce perpetual dividends.

Epidemic Typhus Associated With Flying Squirrels

Since 1976, 30 cases of illness caused by *Rickettsia prowazekii,* the causative organism of epidemic typhus, have been documented serologically in residents of the United States.[1-3] These cases have been unusual in that, unlike classic louse-borne epidemic typhus, they have occurred sporadically, mostly in rural or suburban areas of the Eastern United States. Clinically, patients have presented with fever, headache, myalgia, and skin rash. Seventy-three percent of patients have been ≥20 years of age, and 50% have been male. Most of the patients have had direct or indirect contact with the southern flying squirrel, *Glaucomys volans,* a rodent that frequently nests in the attics of houses during the colder months of the year and is a known reservoir of *R. prowazekii.*[4] It is presumed that infection is acquired from this animal, although the mechanism of transmission is unknown. Of interest to physicians in Georgia is the fact that 10 of the 30 cases of *R. prowazekii* infection have occurred in Georgia, all during the colder months of the year (Figure 1).

Since the causative organism has yet to be isolated from a human case of sporadic *R. prowazekii* infection and since the mechanism of transmission of this disease has yet to be determined, the Georgia Department of Human Resources (GaDHR), in conjunction with the Centers for Disease Control (CDC), is attempting to identify as many cases of this disease as possible during the coming winter months. Therefore, physicians who encounter patients during the winter months with a rickettsial-like illness (fever, headache, myalgia, and skin rash) are encouraged to obtain a sample of venous blood BEFORE STARTING ANTIBIOTICS and to proceed as follows:

1. Have laboratory SEPARATE AND FREEZE THE CLOT from the blood specimen; the serum may be either refrigerated or frozen.
2. Contact Mr. David Smith, GaDHR, Office of Epidemiology, Tel. 404-656-4764, as soon as possible.
3. Obtain convalescent-phase serum sample 2 to 3 weeks later. Submit acute- and convalescent-phase serum specimens together to the state laboratory. If serologic testing confirms infection with *R. prowazekii,* GaDHR or CDC will contact the physician to obtain the initial blood clot for isolation of rickettsia in the laboratory. NOTE: THE CLOT MUST BE KEPT FROZEN, PREFERABLY AT −70°C, IN ORDER FOR RICKETTSIAL ORGANISMS TO REMAIN VIABLE.
4. Following confirmation of a case, GaDHR or CDC will also contact the physician to obtain permission to interview the patient and to perform a site investigation.



Cases of *Rickettsia prowazekii* infection, by month of onset, United States, 1976-1982.

(Reported by R. Keith Sikes, D.V.M., M.P.H., State Epidemiologist, Office of Epidemiology, Division of Public Health, Georgia Department of Human Resources, Atlanta; and Jonathan E. Kaplan, M.D., Division of Viral Diseases, Center for Infectious Diseases, Centers for Disease Control, Atlanta.)

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MAG Position Statement on Health Maintenance Organizations

In 1973, the Federal HMO Act (P.L. 93-222) was signed into law authorizing substantial Federal funds to be spent in the establishment and development of Health Maintenance Organizations. Amendments were passed in 1976 and 1978 increasing the government's commitments to prepaid health care by extending the authorization for grants and loans through fiscal year 1981. Initially, developmental grants for the purpose of studying the feasibility of an HMO can go as high as $2 million each. Subsequent loans to assist in the development and implementation can reach $4 million.

The HMO can take two basic forms, closed-panel or Individual Practice Association (IPA). Under the closed-panel concept, the HMO can employ its own physicians on a salary basis or contract with one or more medical groups to provide care on a prepaid, per capita basis. On the other hand, the HMO can contract with an IPA, a separate legal entity consisting of physicians who collectively enter into contractual arrangements with other parties to provide medical services from their offices to a defined population. Physicians who join must:

1. Sign an agreement to conduct their medical practice in accordance with the purposes and policies of the IPA,
2. Comply with peer review established by the IPA,
3. Accept a portion of the financial risk by placing a percentage of their fee, usually 20%, in a fund which they receive *only* if the IPA operates within certain financial parameters (established actuarially), and
4. Open their records pertaining to the quality of health care to the Commissioner of Human Resources, for the purpose of examination as often as he deems necessary, but at least every five years.

In metropolitan Atlanta, there are four HMOs in various stages of development and others are being considered both in Atlanta and various portions in the state of Georgia. Three of the HMOs under development are IPAs and the other is a church affiliated, closed-panel model. Although the collective enrollment goal of these HMOs is modest (75,000 families within the next three years), the impact of this alternative delivery system should not be underestimated. The ultimate choice of participating in an HMO rests with the individual physician, so each physician must decide whether the HMO's goals and objectives, as well as methods of achieving those goals and objectives by the HMO, are consistent with his or her personal goals in the delivery of medical care.

Superb management is crucial if any HMO-IPA is to have any possibility of achieving their stated goals. The assurance of such high quality management is difficult to ascertain in advance of actual operation.

The Medical Association of Georgia expresses its deepest concern regarding any method of health care delivery that limits the patient's choice of a physician or limits the physician's choice of an appropriate consultant.

The Medical Association of Georgia considers any health care vehicle which invites a physician to increase his or her remuneration by restricting diagnostic and/or treatment services to represent an unacceptable and obvious conflict of interest which is to be avoided at all costs.

The Medical Association of Georgia supports the concept of consultation (second opinion) whenever it is requested by the patient or deemed necessary by the physician. The Association has always held the opinion that careful clinical judgement should be exercised in the selection of patients for hospital care. The Medical Association relies upon collective medical judgement of our peers in order to determine the appropriate levels of patient care. We deplore and condemn the subversion of these traditional medical practices for the purpose of cost reduction, relegating the health of the patient to a secondary role.

(Adopted by the MAG House of Delegates in 1980.)

VA Physician Placement Service

The Veterans Administration (VA) has established a Physician Placement Service in Randolph, Massachusetts, that will enable VA Medical Centers throughout the United States to identify physicians who meet the Specialty needs of the various Medical Centers. The Placement Service allows interested physicians to apply for openings throughout the entire VA system by submitting a single application to the Physician Placement Service.

Through the Physician Placement Service, qualifications and practice preferences are computer "matched" with VA Medical Center requirements. A list of interested, qualified applicants for each available position is generated within 24 hours of receipt of a request from a VA Medical Center. The applications and references of each "matched" applicant are then forwarded to the requesting Medical Center. The Medical Center then arranges interviews, and evaluation and hiring decisions are made.

For further information and application, write to: VA Physician Placement Service, P.O. Box 719, Randolph, MA 02368, or call: 1-800-343-8831 outside Massachusetts (toll free); 1-617-963-8282 Massachusetts residents (collect).

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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 μg/ml and 0.09 μg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	–	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	–
(range)	(70-99%)	(99.5%-100%)	–	–

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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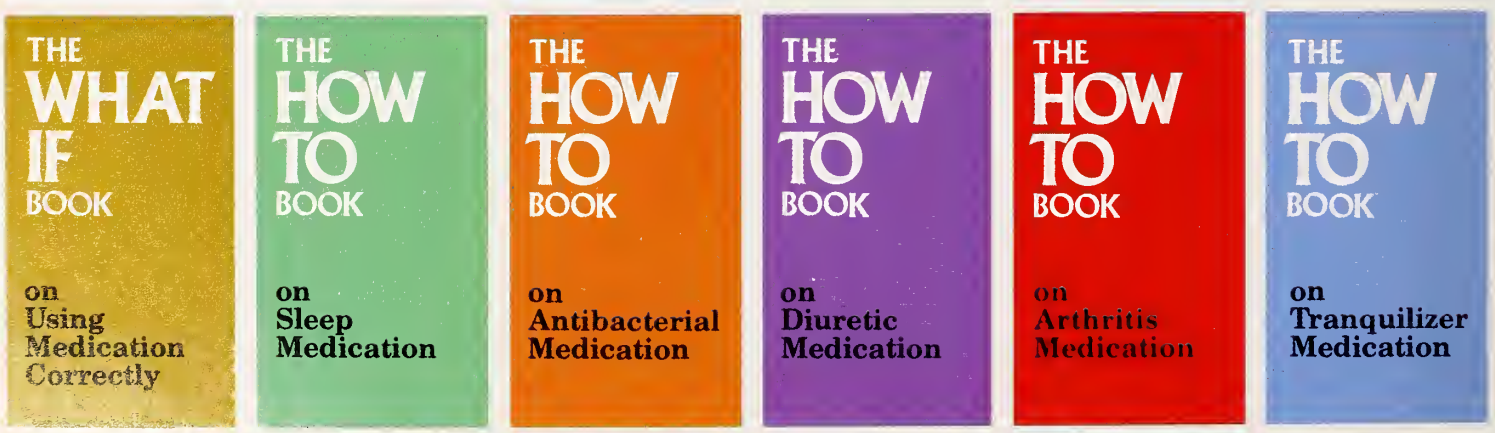
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MEDICAL MEETING CALENDAR

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21-22—*Atlanta:* **Cardiology for the Emergency Department Physician.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-22—*Macon:* **Georgia Rural Health Conference.** Contact Stephen Wright, PhD, Off. of Rural Health, Ga. Southern College, Statesboro 30460. PH:912/681-5144.

21-22—*Macon:* **Second Annual "What's New in Obstetrics and Gynecology."** Category 1 and AAFP prescribed credits. Contact John Souma, MD, Dir., OB/GYN, Med. Ctr. of Central Ga., P.O. Box 6000, Macon 31208. PH:912/744-1692.

21-23—*Atlanta:* **33rd Annual Meeting, Association of American Physicians and Surgeons: Competition in Medicine — Good or Bad News?** Contact Daniel Jordan, MD, 35 Collier Rd., NW, Ste. 385, Atlanta 30309.

22-26—*Atlanta:* **American Assn. of Oral and Maxillofacial Surgeons.** Contact Gary Hoormann, AAOMS, 211 E. Chicago Ave., Chicago, IL 60611. PH:312/642-6446.

25-27—*Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

29—*Macon:* **Rheumatology 1982.** Category 1 credit. Contact John A. Hudson, MD, Med. Ctr. of Central Ga., 784 Spring St., Macon 31210. PH:912/744-1562.

29-30—*Atlanta:* **Chest Radiology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

29-31—*Charleston, SC:* **Ambulatory Electrocardiography.** Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., 65 Inverness Dr. East, Englewood, CO 80112. PH:800/525-8651.

30-Nov. 2— *Atlanta:* **SMA-MAG Scientific Assembly.** AMA, AAFP, ACEP, and ACOG credits. Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800-282-0224 (toll free in Ga.).

NOVEMBER

5—*Birmingham, AL:* **Next Decade: Changes in Sociological and Economic Status of Physicians.** Category 1 credit. Contact Mrs. Dena Metts, Med. Staff Secy., South Highlands Hosp., 1127 S. 12th St., Birmingham, AL 35205. PH:205/250-7703.

10-12—*Atlanta:* **Patient Demonstrations in Interventional Radiology III.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

11-13—*Atlanta:* **34th Annual Meeting, Ga. Academy of Family Physicians.** AMA Category 1 and AAFP prescribed credits. Contact Camille Day, Ste. 205, 11 Corporate Sq., Atlanta 30329. PH:404/321-7445.

12-14—*Callaway Gardens:* **MAG Leadership Conference.** Category 1 credit. Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in Ga.).

15-16—*Atlanta:* **Arthroscopy Need Not Be Frustrating: Diagnostic Arthroscopy.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

17—*Atlanta:* **AMA-MAG Seminar for Physicians: Marketing Strategies for Private Practice.** Contact Stephen Davis, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in Ga.)

DECEMBER

3-4—*Atlanta:* **American Urological Association Videoconference: Prostate Cancer.** Category 1 credit. Contact Alice Henderson, AUA, Box 25147, Houston, TX 77265. PH:713/790-6070.

3-4—*Atlanta:* **Clinical Management of Coronary Disease and Dual-Mode Exercise Testing.** Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH:800/525-8651.

3-5—*Atlanta:* **International Symposium on Medical and Scientific Writing.** Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

4-5—*Atlanta:* **Regional Anesthesia: Surgery, Obstetrics, and Pain.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

9-10—*Atlanta:* **MKSAP VI Review Course.** Contact Registrar, College of Physicians, 4200 Pine St., Philadelphia, PA 19104. PH:800/523-1546.

18—*Atlanta:* **Depression and Anxiety: Treatment and Advances.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

JANUARY — 1983

13-14—*Atlanta:* **Imaging 1983:** Computed Tomography, NMR, Ultrasound. Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

30-Feb. 3—*Cancun, Mexico:* **5th Annual Scottish Rite Pediatric Postgraduate Course: Pediatrics in Review.** Category 1 credit. Contact Judson Hawk, Jr., MD, Scottish Rite Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/256-5252.

Letters to the Editor . . .

More on HMOs

Dear Sir:

As a previous "HMO Provider" (staff model) and now a private practitioner of medicine, I share many of the thoughts contained in Dr. Felder's recent [*Journal*] article ["Health Maintenance Organizations in Atlanta," July, 1982].

HMOs offer virtually nothing new or exciting for the physician. There is no incentive to see patients or provide special services. Advantages such as regular hours, paid vacations, and fewer forms are overstated and offset by many irritating disadvantages. During my HMO tenure, I confronted scores of dissatisfied, frustrated patients led to believe they would receive medical care on demand. Patients expected unlimited office visits, tests, specialty consultations, and after-hours emergency room care. I was in the middle trying to satisfy unreasonable patient expectations and the administration's urgings to cut costs. Cost containment was the primary goal — quality medicine a depersonalized byproduct.

I particularly disliked the weekly utilization sessions organized to judge the appropriateness of consultations, lab procedures (especially x-rays), and emergency room visits. Cost savings were small, and ill feelings developed among the providers. We were forced to defend honest medical decisions in economic terms.

High patient and doctor turnover in our HMO group reflected the level of dissatisfaction among the professional providers and patients. HMOs will continue to attract young primary care physicians just out of training and transient older physicians unable or unwilling to start their own practice or simply looking for the evasive nine-to-five practice. For the physician already in practice, HMO-based medicine (staff model) by comparison is depersonalized, lacks professional incentive, and is beleaguered with unpleasant patient and economic confrontations.

Sincerely,
Marshall R. Levine, M.D.
Internist
Atlanta
Aug. 6, 1982

(An Open Letter To My Friend, Louie [Felder])

Dear Louie:

You are such a good friend of mine, and I have such high regard for your innate intelligence, that it grieves me to see your editorial entitled, "Health Maintenance Organizations in Atlanta" in the July, 1982, issue of the *Journal of the Medical Association of Georgia* and to find myself compelled to take pen in hand and question some of your statements. But do so I must, while trusting your good and kind understanding of my benign motives.

Now at the beginning, let me place myself squarely on the side of our present system of health care — I am happy with my lot and my patients seem to share a similar feeling in regard to the care which they receive in my office. I view the HMO movement as an infringement upon my happiness and my tranquility and on the idyllic medical care which in my own view is dispensed in this office of mine. Nonetheless, should I open my eyes and see, I must confront the real presence of the HMO movement in my community. I may dislike it, as I do; I may even malign and discredit it — but stamp it out in the near future, I shall not. And so, I come to your letter.

You state — "It is obvious that a great deal of control is required by the HMO as to what their physicians can furnish." And how true this statement is; yet would you not defend this as a principle we all should have been practicing through the years? — that is, controlling those things which we provide our patients within the realm of reason and need, rather than indiscriminately "spraying" the public with unnecessary tests and services.

You go on to state — "To the physician . . . belonging to an HMO markedly restricts his freedom." And I would have to question that statement — question it with regards as to whether or not there are significantly more restrictions placed upon us in that context than those already presented by state boards, federal regulations, hospital requirements, and, something I know you are burdened with, the restrictions of one's own conscience.

"He will have to tell the patient what the HMO can and cannot afford in the way of medical care." And I would again say to you that this seems to be something that we all should have been doing carefully through the years and hopefully are more keenly aware of today.

"He will have to compete with the other physicians in the HMO for the dollars available to the HMO and with physicians outside the HMO for patient satisfaction." And here I would have to say to you that I have always disdained the word "compete" in the field of medicine. I have always liked to think, as did Hugh Wood when he was Dean of the Emory University School of Medicine, that, "I like to think of a patient having a doctor and not a doctor having a patient." I would rather envision the happy practice of medicine in a healing and comforting context rather than an economical and competitive one. And as for "patient satisfaction," would we not both hope that it flows from the adequacy, both technical and humanistic, of an individual's conduct in his medical practice?

You go on to say — "It will depersonalize medicine and undermine his identity as well as his ideology." Perhaps you are right here, but again I would like to think that I am in control of "depersonalizing" my practice or of losing my "identity" and my "ideology" rather than having it occur as the result of a bureaucratic mechanism. You see, Louie, I still have confidence — rationally founded I hope — that you and I are in control of such things as identity and ideology and patient satisfaction and are losing control mostly of financing mechanisms. Perhaps that is regrettable — I'm not sure. I do know that Medicare and Medicaid did not depersonalize medicine in my practice. I hasten to add that this is not an affirmation of my fondness for these programs but a simple statement

of their effect upon me personally. You see, Louie, in surgery one must make the best incision he can — put in the stitches as best he may — try for the best result in every patient — regardless of the form filled out by the secretary at the end of the encounter — regardless of whether the patient chose him as his surgeon or fell lucklessly into his hands through some sifting mechanism — regardless of his pay or lack of it. And so it is with you, Louie.

I am about at the end of your editorial now. "It would tend to herd people like cattle into various chutes." Have you ever been to the Mayo Clinic, Louie? They go there by the thousands each morning — not through chutes but through swinging doors — and line up and sign registers and file dutifully through the corridors to assigned people on the staff. The quality of the care they receive depends on the individuals at the end of that "herding" — not upon the mechanism of getting them from the airport through the doors and into the "chutes" and into the private offices.

But of course, you and I do agree at the end — "All the above to the contrary notwithstanding, HMOs are in Atlanta, and Atlanta physicians will have to deal with them." That is the crux of the thing, of course. You and I remember when everybody paid either as they came through the office or at the end of the month with cash or check — and then we dealt with an ever-increasing number of third party payers — and then with Medicare and Medicaid — and now with the HMO. We will keep going, Louie, you and I — at least we will if we remember what my father said at the Emory gate when he got on the streetcar and headed back to Atlanta after that long ride from Alabama. He said, "Son, just remember who you are." And I think that is all we have to do. I think if you and I keep doing things the way we have the past few years, we will be here a long time talking about what went wrong with the HMO movement.

Best regards, Louie,
Charles R. Underwood, M.D.
General Surgeon
Marietta
Aug. 4, 1982

Roentgen Cephalopelvimetry

Dear Sir:

The recent article by Russell Wigh and C. I. Bryans, Jr., regarding roentgen cephalopelvimetry which appeared in the July, 1982, issue of the *Journal* concludes that the examination can have a high medical efficacy.[1] Laube, et al.,[2] comparing clinical management plans between prepelvimetry and postpelvimetry patients in one hundred four consecutive patients on whom x-ray pelvimetry was performed at the University of Iowa Hospitals, suggest that x-ray pelvimetry has very little impact on immediate clinical management of labor and delivery. Clear evidence that x-ray pelvimetry improves perinatal and maternal outcome is lacking. This position is reflected in a statement recommending limiting the routine use of x-ray pelvimetry issued by the FDA.[3]

The Medical Audit Committee of Henry General Hospital, a 100-bed suburban facility [in Stockbridge], examined the use of pelvimetry data in a routine audit of cesarean sections performed at the hospital over a 6-month period. A difference between manual pelvimetry and x-ray pelvimetry was noted in 3 of the 24 cases examined. Tighter criteria for diagnosis of cephalopelvic disproportion were noted for x-ray pelvimetry, a finding which concurs with the impression of Wigh and Bryans at the Medical College of Georgia that manual pelvimetry may provide misinformation. However, it was apparent that x-ray pelvimetry had very little impact on immediate clinical management of labor and delivery at this hospital, a finding which supports the position of Laube and underscores the statement issued by the FDA.

Yours,
Kenneth Alonso, MD, FACP
Henry General Hospital
Stockbridge
July 18, 1982

References

1. Wigh RE, Bryans CI Jr. Roentgen cephalopelvimetry. J Med Assoc Ga 1982; 71:475-481.
2. Laube D, Warner M, Cruikshank D. A prospective evaluation of x-ray pelvimetry. JAMA 1981; 246:2187-2188.
3. FDA Drug Bulletin 1981; 11:22.

"No Easy Way"

Dear Sir:

I am glad to have the opportunity to read your editorial, "No Easy Way," in the April, 1982, issue of the *Journal of the Medical Association of Georgia*.

It is reassuring to know that you have compassion for those who suffer and a desire to meet their needs. I like your positive approach on viewing suffering as a growing and maturing experience and as a necessary part of life.

Very truly yours,
Jannelle Jones McRee
Elberton
Aug. 20, 1982

A first for the Association . . .

ONE OF THE THINGS that makes our federation of organized medicine effective is ample and free exchange of information. Communication among physicians at all levels — county, state, and national — has allowed all of us to become better informed on controversial issues, to exchange ideas, and to formulate the best courses of action.

We have seen it work best at the national level, where the AMA has for a decade conducted leadership conferences. In Chicago every spring, hundreds of physicians and society staff members gather for communication, education, and camaraderie.

The Medical Association of Georgia intends to do the same thing in Georgia. On November 12-14 at Callaway Gardens, we will hold our first Leadership Conference. We have scheduled an impressive array of nationally known speakers to address topics facing physicians in our state: hospital/medical staff relations, credentialing and quality assurance, medicine/business coalitions, peer review, professional liability, and more. Lots of time is set for questions and answers, plus special discussion groups on Friday for exchange of ideas. The schedule will of course allow time on Saturday and Sunday for recreation at Callaway.

What's more, the MAG is charging no registration fee for attendees. We are sponsoring the Leadership Conference as a service and educational opportunity for those who will help make decisions affecting medical and health care in Georgia.

Invited to the Leadership Conference are all those who hold leadership positions in the state medical community, some 900 representatives:

—from county medical societies, the "grassroots" of the federation: all officers, board members, staff, and delegates and alternates to the MAG House;
—from state specialty societies: officers and staff members;
—from Georgia's 200 hospitals: chiefs of medical staffs;
—from the MAG: officers, board members, and committee chairmen;
—from the Auxiliary: officers, committee

The MAG Lea

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chairmen, and county presidents;
—and others, too: including the board of MAG Mutual Insurance Company and the board of the Georgia Medical Care Foundation.

In mid-August, the preliminary program was mailed to the above individuals. Friday's agenda features a whole day on hospital/medical staff relationships. So important are the issues of medical staff bylaws, delineation of privileges, and JCAH requirements that the MAG House of Delegates last April called for a conference treating these themes. After presentations in the morning, workshops in three major areas will be held, from which we anticipate suggestions for future action that can be presented to all attendees.

On Friday afternoon also will be the first organizational meeting for the proposed MAG Section on Hospital Medical Staffs. The Section will provide a mechanism through which the MAG will deal with a variety of circumstances, such as the growing competition for patients between hospitals and physicians, expansion of satellite clinics and "emergicenters," and the rise in physicians with negotiated contractual relations with hospitals.

Then, the Chairman of MAG's Board of Directors, Dr. Jack A. Raines of Columbus, will set forth a few of the reasons why the Medical Association of Georgia is considered the "umbrella" organization for our state's physicians. A social hour for all attendees will follow.

On Saturday morning, all attendees are invited to a general session. Featured will be a review of Friday's discussion on hospital/medical staff relations, as well as presentations on medicine/business coalitions for cost containment and current developments in peer review. The afternoon is open for golf, tennis, or simply enjoyment of the outdoors at Callaway. In addition, there is the Georgia-Auburn football game at Auburn, only 40 miles away. If enough people want to go, the MAG will charter a bus to arrive at kickoff time, 1:30 p.m. CST. A big reception is planned Saturday evening for all conference attendees and guests.

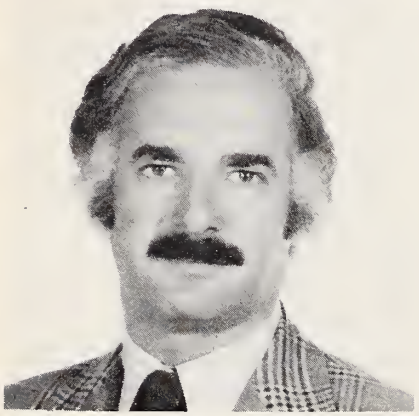
Sunday morning again features a general session.



Dr. Derrill Crowe, President of the Mutual Assurance Society of Alabama, will address the issue of professional liability on Sunday.



Dr. Jack A. Raines, of Columbus, highlights the program Friday afternoon with "MAG: Getting Things Done for Organized Medicine."



Dr. Richard F. Corlin, of Santa Monica, CA, will speak on "Changing Trends in the Medical Care Environment" on Friday. He will also survey hospital/medical staff relationships on Saturday morning.



Mr. Kent Masterson Brown will address legal aspects of hospital/medical staff relationships. An attorney in Lexington, Kentucky, he has represented physicians in a variety of legal disputes.

The always important subject of professional liability will be discussed, as well as political issues facing physicians. Rounding out the program will be a stem-winder on membership and recruitment in the state's various medical societies. The Conference will adjourn shortly after noon.

Here is the hour-by-hour breakdown of our schedule:

FRIDAY, NOVEMBER 12

Hospital/Medical Staff Relationships

GENERAL SESSION — *Peach and Willow Ballrooms*

9:00-9:45 **Credentialing and Quality Assurance**
WILLIAM R. FIFER, M.D., Clinical Professor of Medicine and Public Health, University of Minneapolis, MN

9:45-10:30 **Legal Responsibilities and Liabilities of the Medical Staff, Administration and Governing Body**
KENT MASTERSON BROWN, J.D., Attorney at Law, Lexington, KY, and General Counsel of the Limited Legal Consultation Service of the American Association of American Physicians and Surgeons, Inc.

10:30-10:45 **Coffee Break**

10:45-11:30 **Changing Trends in the Medical Care Environment**
RICHARD F. CORLIN, M.D., Clinical Professor of Medicine, UCLA School of Medicine, Santa Monica, CA

11:30-12:00 **Question and Answer/Discussion**

12:00-1:45 **Lunch on Your Own**

1:45-2:45 **Workshops on the Morning Topics** — *"Breakout rooms"*
—**Credentialing and Quality Assurance** (Dr. Fifer, moderator) — *Dogwood I*
—**Legal Issues in the Hospital** (Mr. Brown, moderator) — *Magnolia*
—**Changing Trends in Medical Care** (Dr. Corlin, moderator) — *Dogwood II*

GENERAL SESSION — *Peach and Willow*

2:45-3:45 **Suggestions from the Workshops**
DR. FIFER, MR. BROWN and DR. CORLIN will present summaries

3:45-4:30 **MAG Section on Hospital Medical Staffs**
CHARLES D. HOLLIS, JR., M.D., President, Medical Association of Georgia, Albany

4:30-5:00 **MAG: Getting Things Done for Organized Medicine**
JACK A. RAINES, M.D., Chairman, MAG Board of Directors, Columbus

6:00-7:00 **Social Hour** — *Magnolia*

SATURDAY, NOVEMBER 13

GENERAL SESSION — *Peach and Willow*

9:00-10:00 **Hospital/Medical Staff Relations: An Overview**
DR. CORLIN

10:00-10:15 **Coffee Break**

10:15-11:00 **Medicine/Business Coalitions**
Ronald E. Henderson, M.D., President, Medical Association of the State of Alabama and member, Birmingham medicine-business coalition

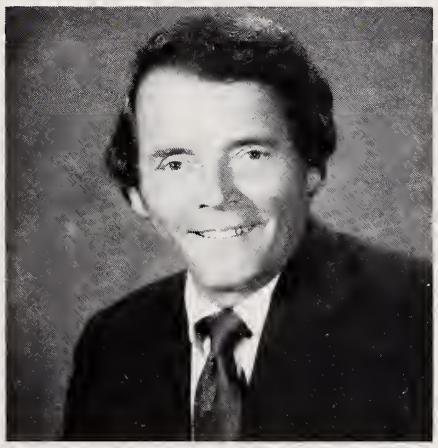
Dr. Ronald E. Henderson, President of the Medical Association of the State of Alabama will share his experiences with the Birmingham medicine-business coalition Saturday morning.



Dr. Wyndham B. Blanton, Jr., of Richmond, is Vice President for Medical Affairs of Charter Medical Corporation. His presentation on peer review is scheduled for Saturday morning.



James P. Low, of Washington, D.C., former president of the American Society of Association Executives, will speak Sunday on membership and recruitment in your society.



Dr. Charles Hollis, Jr., President of the MAG, will moderate the organizational meeting of the MAG's proposed Section on Hospital Medical Staffs on Friday afternoon.



11:00-12:00 **Peer Review After PSRO**
WYNDHAM B. BLANTON, JR., M.D., Vice-President, Medical Affairs, Charter Medical Corporation, Richmond, VA

AFTERNOON — On Your Own

6:30-8:00 **Reception** — *Sweetbay Room*

SUNDAY, NOVEMBER 14

GENERAL SESSION — *Peach and Willow*

9:00-9:45 **Professional Liability**
A. DERRILL CROWE, M.D., President, Mutual Assurance Society of Alabama, Birmingham

9:45-10:30 **Political and Economic Issues Facing Physicians in Georgia**
ED JENKINS, U.S. Representative, Ninth District of Georgia

10:30-11:00 **Coffee Break**

11:00-11:30 **Membership and Recruitment in Your Society**
JAMES P. LOW, President, Low & McManis, Ltd., Washington, D.C.

11:30 **Conference Adjourns**

CME Credit: As an organization accredited for continuing medical education, the Medical Association of Georgia designates this continuing medical education activity as meeting the criteria for 12 credit hours of the Physician's Recognition Award of the American Medical Association.

Faculty

WYNDHAM B. BLANTON, JR., M.D. — A native of Richmond, VA, Dr. Blanton began private practice in that city, specializing in internal medicine and allergy. He is a member of the Virginia South Central PSRO and has served on the National Professional Standards Review Council, the Clinical Faculty and Quality Review Panel of the Joint Commission on Accreditation of Hospitals, and the Peer Review Task Force, American Society of Internal Medicine. Since 1973 he has served as Vice President for Medical Affairs of the Charter Medical Corporation.

KENT MASTERSON BROWN, J.D.— After graduation from the School of Law at Washington and Lee University, Mr. Brown established practice in Lexington, Kentucky, specializing in health law. He has represented physicians in such disputes as the constitutionality of the Kentucky medical liability statute; the constitutionality of the National Health Planning and Resources Development Act of 1974; and the application of state antitrust laws to the practice of medicine in New York. He is a member and faculty member of the National Health Lawyers Association.

RICHARD F. CORLIN, M.D. — Dr. Corlin received his medical degree from Hahnemann Medical College in Philadelphia and conducted his internship/residency in medicine at Hahnemann Hos-

pital. He completed a fellowship in gastroenterology at UCLA in 1970-71. He served as President of the Los Angeles County Medical Association; is currently the Vice Speaker of the California Medical Association; and serves as Alternate Delegate to the AMA House and as a member of the AMA Council on Long Range Planning and Development.

A. DERRILL CROWE, M.D. — Dr. Crowe was born, raised, and educated in Alabama. He graduated from the University Medical College, completed his surgical residency in Fairfield and urological residency in Birmingham. Since 1967, he has been engaged in private practice in urology at Birmingham. A member of the State Board of Medical Examiners, the State Committee of the Department of Public Health, and the Board of Censors of the state medical association, Dr. Crowe is President of the Mutual Assurance Society of Alabama.

WILLIAM R. FIFER, M.D. — An internist with 15 years' experience in multispecialty group practice, Dr. Fifer has spent a decade in medical education and health services research at the University of Minnesota. In the area of medical care evaluation and quality assurance, he has served as consultant to the JCAH, the American Hospital Association, the American College of Hospital Administrators, and the U.S. Department of Health and Human Resources. His consulting group, Clayton, Fifer Associates, is headquartered in Minneapolis.

RONALD E. HENDERSON, M.D. — Earning his medical degree at the Medical College of Alabama, Dr. Henderson entered general practice, then conducted his residency training in obstetrics and gynecology at Birmingham. Since 1970, he has held the position of Clinical Assistant Professor at the Medical College of Alabama and as Chief of the Medical Staff at St. Vincent's Hospital in Birmingham. He has recently been elected to the AMA Council on Medical Service and has served as a delegate and reference committee chairman in the AMA House of Delegates. In addition to his duties as President of the Medical Association of the State of Alabama, he is a member of various business and civic groups in Birmingham.

CHARLES D. HOLLIS, JR., M.D. — Dr. Hollis has practiced internal medicine in Albany since 1954 and has long been prominent in the activities of the Dougherty County Medical Society and of the MAG. He has also served as President of the Georgia Society of Internal Medicine. As well as being President of the MAG, Dr. Hollis is President and Chairman of the Board of Directors of MAG Mutual Insurance Company; an Alternate Delegate to the AMA House; a member of the Governor's Advisory Council on Medical Malpractice; and a Council



Dr. William Fifer of Minneapolis will speak on "Credentialing and Quality Assurance."



Congressman Ed Jenkins of Georgia's Ninth District will speak on political issues facing physicians.

member for the Georgia Chapter, American College of Physicians.

JAMES P. LOW — Mr. Low is Chairman of the Board of International Meetings and Marketing, Inc., a marketing company specializing in the development of U.S. association and corporate meeting business for a select group of international destinations. He is also President and Chief Executive Director of Dynamics, Inc., a company involved in travel, government relations, association leasing, consulting, and land development. For 16 years, Mr. Low was President of the American Society of Association Executives. Before joining ASAE, he for 10 years was Manager, Association Department, Chamber of Commerce of the United States.

JACK A. RAINES, M.D. — After graduating from the University of Tennessee College of Medicine, Dr. Raines practiced in Memphis before taking residency training and a fellowship in psychiatry in St. Louis. For 12 years he was Clinical Director of the Bradley Center Hospital in Columbus. Since 1975, he has been engaged in private practice in that city. Dr. Raines has held the presidency of the Ga. Psychiatric Association and the Muscogee County Medical Society. Serving on the MAG Board of Directors since 1968, he is currently its Chairman.

CONGRESSMAN ED JENKINS — A native of northwest Georgia, Mr. Jenkins attended Young Harris College and graduated from the University of Georgia Law School. Since then he has practiced law in Jasper, has served as Assistant U.S. Attorney for north Georgia, and has been executive secretary to former Congressman Phil Landrum. Elected to Congress from Georgia's Ninth District in 1976, Ed Jenkins served on the influential House Ways and Means Committee. Aside from other committee appointments, Mr. Jenkins is also a member of the newly formed Conservative Democratic Forum.

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J-9043-4 July 1981



In the treatment of insomnia

Good mornings start with restful nights.

Dalmane *(flurazepam HCl/Roche)* patients fall asleep faster, sleep longer and seldom awaken with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.[1] In a double-blind crossover study of 42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.[2] This difference was highly significant ($p<0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.[3]

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.[4] The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.[5-8] Since the risk of oversedation, dizziness, confu-

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sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.[1] Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.[9,10] However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.[11] When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

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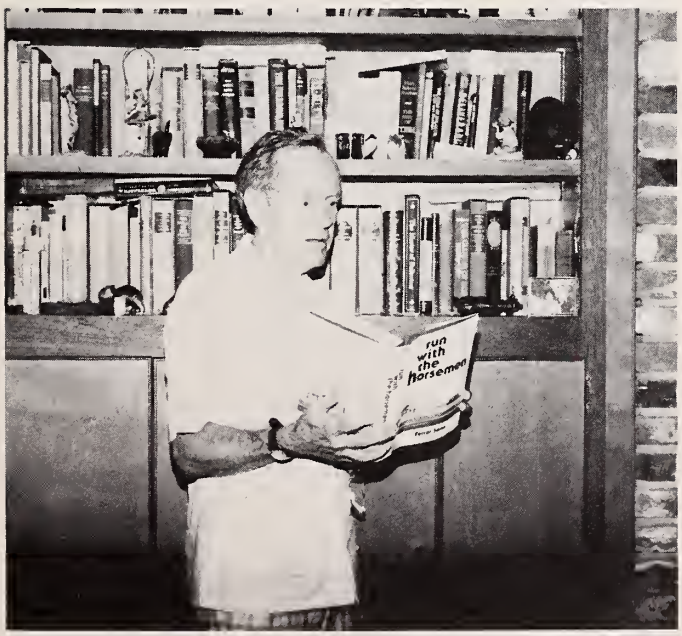
The insight given here into the mind behind the pen will enhance your appreciation of the book by this physician-author.

An Interview With Dr. Ferrol Sams, Author of *Run With the Horsemen*

EVELYN WARD GAY, *Decatur**

EQUALLY AS PLEASANT as reading a good book is interviewing the person who authored it. As he talks about his creation, his eyes sparkling with satisfaction, he reveals himself as openly as the lines he has written upon the pages. It would be unthinkable to question his statement that he "loves the feel of writing" and has "a reverence for the written word." Even before he says it, you know that here is an author who has written for the sheer joy of telling a story.

"I already have my best reward," he says, looking straight at you. "I've held the book in my hands."



Dr. Ferrol Sams shows off his new book, *Run With the Horsemen.*

Such an author is Ferrol Sams, family practitioner of Fayetteville, whose book, *Run With the Horsemen,* has just been released by Peachtree Publishers Limited of Atlanta. Known to many of his patients around the Fayette County countryside as Dr. Ferrol Sams, and to others as "Ole Man Ferrol's son," he is to his friends, and especially to those of 1940s vintage, first and always just "Sambo," a devil in lamb's clothing, ready at any time with a practical joke.

He is a scholar, capable of quoting from the classics, the Scriptures, his ancestors, and the black folks who once inhabited his beloved rural Georgia. He is a sensitive human being, warm and understanding, and he has produced an almost-human book that everyone should read.

The blurb on the jacket says that the book is "delicate, raw, charming, and so honest it makes your teeth hurt." It is all of that and more. It is the story of a pint-sized boy growing up in "the country" 6 miles south of town, between the two World Wars, and the bitter-sweet relationships he shares with members of his extended family, his classmates "in town," and the workers on the ancestral land, over which a giant of a father rules, and under the Christian guidance of a quiet and martyred mother.

The title is taken from a Biblical passage which evades the memory until about three-fourths of the way through the 422-page tome, when it hits the reader suddenly during a moment of crisis with such emotional impact that the theme and the reason for the telling of the story become clear and obvious.

Dr. Sams used only two references during the 18 months it took him to complete the book — the Bible and a good dictionary. He didn't need anything else. He has an amazing memory for detail and a remark-

* Mrs. Gay is the corresponding secretary and former historian of the Auxiliary of the Medical Association of Georgia. Send reprint requests to her at 911 Vistavia Circle, Decatur, GA 30033.

able concept of exact characterization which few writers have mastered. Each morning he arose early, sat down at the big table at his home just off the main street of the little town where he lives, and worked with a pencil and paper from 5:30 until 7:30. He established a faithful routine, broken only occasionally by what he calls "stressful times." His father died in 1979; his mother followed in 1980. A few times he read parts of the manuscript to his wife or one of his four children. When it was finished and typed by one of his three sisters, he knew that it pleased him, but he wasn't sure that it would have the same appeal to anyone who was not raised on a farm in the South. His worries were unnecessary. Everyone who has read it is better for having done so.

The publisher calls the book "a novel." Dr. Sams admits to having lived a life quite similar to that of his main character, called "the boy." His ambition, as was the boy's, was to become a doctor. He had the aptitude and the scholastic record for it. After receiving his undergraduate education at Mercer University in Macon, he enrolled in the Emory University School of Medicine.

Run With the Horsemen, ***set in the rural South between the two World Wars, is "delicate, raw, charming, and so honest it makes your teeth hurt."***

But it was wartime and many of his old friends were fighting and dying on foreign soil. He began to wrestle with his conscience. Some of his adventuresome spirit returned to take his mind from his medical studies. He thought it would be great to become a paratrooper. The army officials laughed at him. He wasn't big enough for that. In his second year at Emory, he found himself with an overpowering desire to experience active military service.

Once the fact of leaving medical school had been accomplished, he "felt that a burden had been lifted." He was sent first to Camp Grant in Illinois for 6 weeks in an advanced surgical training school, where he would learn to become a medical aide instead of a doctor, turning down a place in Officers Candidate School which had been offered him. From Camp Kilmer, New Jersey, he later boarded the Queen Mary for overseas duty in Normandy, "where we followed Patton around" in a tent housing a mobile hospital unit. Trained as an anesthetist, he spent the next 3 years on military duty.



Dr. Ferrol Sams and his wife, Dr. Helen Fletcher Sams, enjoy growing flowers and other plants on their estate at Fayetteville.

After his discharge from the army he returned to the Emory University School of Medicine where he was graduated in 1949. While there he met and married a fellow student, Helen Fletcher, from Greensboro, Florida; this, he declares, was "the best thing that ever happened to me."

The two physicians have practiced together since their return to his home county after residency training, and they have been joined recently by two of their sons who are also graduates of the Emory University School of Medicine. They have one other son who is a lawyer, a daughter, and five grandchildren.

Dr. Ferrol Sams is interested in the training of future physicians. He is a visiting clinical professor of medicine at Emory and often takes students in with him during their elective periods to show them firsthand what it means to be engaged in a rural medical practice. As evidence of the high regard in which he is held by the students, he recently was named to membership in the Emory Chapter of Alpha Omega Alpha, a national honorary medical society.

The first printing of 10,000 copies of *Run With the Horsemen* has already been taken up by booksellers, and a second printing is underway. Dr. Sams is into the seventh chapter of a sequel to his story and has signed a contract for its publication with the same company.

Buy the book and read it. You'll never regret it. And don't throw away the dust jacket. Keep it on a shelf where you can glance now and then at its sketches of small-town life — the little church, the courthouse with its ancient clock tower, the main house with a shack nearby — and be reminded nostalgically of a time that was.

The concept of hospice care is discussed, pointing up achievements made and problems still to be resolved.

Hospice Care — An Alternative

PAUL T. WERNER, M.D., *Macon**

The country's developing hospice programs for the terminally ill depend upon referral from the professional medical community for patient care services. It is also imperative that members of the professional medical community in Georgia understand the role of the hospice and work actively to integrate it into the total caring community. Rich rewards of improved patient care, satisfactory symptom control, and resolution of grief and bereavement in the survivors are some of the benefits available to physicians.

The hospice as a concept of care is hundreds of years old. It has been largely refined by the work of Dr. Cicely Saunders at St. Joseph's Hospice and St. Christopher's Hospice in London. From these germinal centers, representatives have spread across Europe and the United States.

Hundreds of communities have programs underway or in the planning stages, and teaching programs have been initiated by several of these hospices. The National Hospice Organization operates from McLean, Virginia.

The Department of Health and Human Services (DHHS) is conducting a special hospice demonstrating program. This program allows 26 hospice projects to apply for special exemptions from Medicare and Medicaid rules and regulations. Hospice providers contend that their services for the terminally ill are less expensive than acute care hospital treatment for the same services. This special program will produce data about this and may lead to coverage of hospice services under these government programs. Certain insurance companies are also conducting experimental programs in financing hospice services, and some offer an optional coverage package.

* Dr. Werner is Associate Professor of Family and Community Medicine, Mercer University School of Medicine, Macon, GA 31207. Send reprint requests to him.

The Program of Care

The hospice system offers a whole patient program of care for terminally ill patients and their families by using an interdisciplinary approach to provide symptomatic relief for the dying patient and support for the bereaved survivors. As a program of care, the hospice does not depend on a physical structure to accomplish its work. Many programs choose to operate inpatient settings, either as a free-standing unit or as part of an existing hospital or nursing facility. These units may also be called "hospices," but it is the *manner of caring* not the place that denotes the presence of a hospice program. Most hospices aim to keep the terminally ill patient at home for all or nearly all of the last stages of life, using the inpatient setting only to manage those symptoms in the patient (eg, pain, coma, incontinence) or the family (eg, fatigue, profound grief, family discord) that cannot be controlled with the patient at home. As soon as symptoms are controlled, the patient returns home. Those programs with inpatient services almost uniformly provide home services or contract for them through a home nursing provider.

In all cases, the patient is approached in a holistic fashion, recognizing those elements of the patient's physical, social, emotional, and spiritual life that are unique, and seeking to restore the blend of those elements that represent homeostasis for the individual and the family. Physical symptoms are often the most obvious and may be the primary reason for referral. Hospices offer expert care in the practical therapeutics (eg, for chronic pain, gastrointestinal dysfunction, and skin and mouth care). At the same time, support of the patient's emotional life with empathic listening, counseling, and careful use of drug therapy is provided. Each dying patient perceives some meaning or spiritual quality to the dying

experience, be it positive or negative. This may be expressed in religious or existential terms. The hospice environment values these aspects of spiritual life, encourages their exploration, and provides pastoral or counseling care where appropriate and desired.

To the hospice team, the social aspect of dying is perhaps second only to the physical in importance. When a patient dies, the family context also dies — it can no longer exist as it previously did. It must grieve, heal, and rebuild with the realization that a loved one is gone. The hospice provides a source of support for the family before and after the patient's death. Before, it provides caring support, encourages the family to assume as much care for the patient as it wishes, and fosters communication among the family members and between the family and the community, especially in the medical arena. After, it provides follow-up bereavement care, meeting with the survivors on key family anniversary dates and traditional holidays when the memories are acutely vivid and painful. The hospice team provides a bridge back to activity in the larger community, preventing social isolation.

It is the goal of hospice programs not to compete but to work cooperatively with the professional medical community in the care of the terminally ill patient.

Teams form the care-giving element. The hospice successfully puts into action an interdisciplinary approach, usually including nurses, social workers, physicians, lay volunteers, pastoral care providers, and others such as psychologists, nutritionists, and therapists. Many "turf" problems have been solved, and models of group process, sharing of responsibility, and growing interdisciplinary dependence can be seen in the hospice teams.

Because only terminally ill patients are admitted to a hospice program, the emphasis is on symptomatic control. The goal is to allow the patient to be pain free, alert, and able to participate in decisions about himself or herself and the family for a maximum amount of time. To achieve this, hospice workers must become masters of detail in order to provide changes small and large to reach these goals. Clinical pharmacology and practical nursing skills are no more important than interpersonal abilities and an empathic ability to be with the patient and family.

Challenges Ahead

The use of volunteers, the development of standards for hospice care, training of staff members, and the settling of insurance coverage issues for malpractice and liability will probably be resolved as hospice programs continue to operate.

Another problem to be solved is the method of payment for hospice services. Traditional third party coverage has not included the care of dying patients outside the hospital. Also, bereavement care for survivors and payment for treatment of psychologic and emotional symptoms by non-medical professionals are issues to be solved.

Certain insurance companies are conducting experimental programs in financing hospice services, which are believed to cost less than traditional, acute care hospital services for the terminally ill.

Another key issue is the proper integration of hospice services into the medical service community. The precise role of inpatient and home hospice care in relation to active oncology units, large metropolitan hospitals, and nursing homes still remains to be defined.

Hospice in Georgia

Many individuals and groups are interested in hospice in Georgia. At present, there are a few directly providing hospice care. Groups working on hospice or providing services exist in Atlanta, Decatur, Augusta, Savannah, Columbus, Brunswick, and Macon. In 1979, the Georgia Hospice Organization, Inc., a non-profit tax exempt corporation, was organized to promote and insure the availability of high quality care to the terminally ill and their families. Other purposes of the Georgia Hospice Organization include: the development and coordination of communication between various groups and individuals related to or interested in hospice care, education of the public and health care delivery professionals, and the cultivation of a statewide resource linkage for families, patients, and service providers who care for the terminally ill.

Hospice and Physicians

New hospice programs, like those in Georgia, are evolving by the hundreds in communities of all sizes. Each needs the support of dedicated individuals to grow and provide care. Practicing physicians need to support hospice efforts in their communities. Teachers should likewise support the hospice as a natural place to train residents and students in basic precepts of medicine. No other setting provides such a rich experiential setting, concentrating so much of medicine into a single program. Learners are exposed to whole patient care, team care, elements of death and dying, family life cycles, clinical medicine and pharmacology, practical nursing

skills, crisis intervention, family unit care, continuity experiences, interpersonal skills (both with patients and coworkers), and elements of community leadership and medicine. Research in hospice care provides a significant area for study.

Hospices in turn have much to gain from medicine, primarily physician support. This critical area of need is often most difficult to meet. The natural predisposition of medicine to care for patients is welcomed by the hospice. The attention to behavioral, spiritual, and interpersonal issues that many physicians can show will strengthen the hospice program. Finally, through referrals and cooperation, the physician can be a liaison with the medical community to provide education and attitudinal changes that are necessary to support the hospice.

Suggested Reading

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The principal advantages of CO_2 laser therapy are precision, probable elimination of the infecting agent, and rapid healing without scar formation.

Carbon Dioxide Laser Surgery for Condylomata Acuminata

JOHN L. POWELL, M.D., *Atlanta**

Abstract

Condylomata acuminata viruses account for a significant number of venereal infections in the Western world and constitute a major public health problem. Unfortunately, conventional therapeutic measures have been inconsistent and largely unsuccessful in the elimination of genital warts. An experience with 25 women using the carbon dioxide laser for evaporation of viral warts is presented. The principal advantages of CO_2 laser therapy are precision which results in sparing of normal tissue, probable elimination of the infecting agent, and rapid healing without scar formation.

CONDYLOMATA ACUMINATA result from infection with a DNA virus of the papova group. In recent years, there has been a marked increase in the occurrence of condylomatas in patients seen in physicians' offices and gynecologic clinics. According to the Centers for Disease Control,[1] venereal warts in women rank fourth in prevalence in patients seeking care in sexually transmissible disease clinics in this country.

Previous Experiences With Other Therapies

A well-known dermatologic cliché is that it is much easier to treat cancer of the skin than venereal warts. The difficulties encountered in the management of patients with condylomata are evidenced by the multiplicity of treatments which have been used. Treatments ranging from mental suggestion, local applications of Fowler's solution, colchicine, formalin, cantharidin, acetic acid, nitric acid, and 5-fluorouracil (5-FU) have been tried. More recently, nonoxynol-9, liquid nitrogen, ultrasound, cryosurgery, electrocoagulation, radiation, scalpel excision, and vaccination have been used.

The use of 5-FU cream may be prolonged and may cause discomfort because of extensive excoriation of both normal and abnormal tissues. Excision and cauterization are disadvantageous because they cause scar formation, frequently require general anesthesia, and may be associated with significant blood loss and infection, especially during pregnancy. Cryosurgical probes rarely fit the lesions appropriately, and cryosurgical therapy for large lesions leads to massive tissue destruction, slough, edema, and profuse discharge.

Despite its many shortcomings, including inconsistent results and toxicity, podophyllum has been the most frequently used medication for the control of condylomata acuminata. Podophyllum, an antimitotic agent, should never be used in pregnancy or on bulky lesions. Coma, flaccid paralysis, hypokalemia, and death have been reported in humans and teratogenicity in rats when podophyllum was used.[2]

In 1978, Powell[3] presented his experience in the management of 67 patients with condylomata who were treated with autogenous vaccine; he achieved 76% excellent results. Difficulties in proper preparation of the autogenous vaccine, however, and Food and Drug Administration regulations in regard to shipping the vaccine across state lines mitigate against the practicality of this method of treatment, but it may be useful in selected chronic, recurrent cases. Interferon shows great promise in the treat-

* Dr. Powell practices gynecologic oncology at St. Joseph's Hospital. Send reprint requests to him at 5669 Peachtree-Dunwoody Rd., NE, Suite 100, Atlanta, GA 30342.

ment of papillomatosis and other viral infections but is in very limited supply and quite expensive.

Advantages of Carbon Dioxide Laser Surgery

Because of dissatisfaction with the results of treatment with podophyllum and other commonly used methods, it was decided to use carbon dioxide (CO_2) laser surgery in the management of patients with condylomata acuminata. CO_2 laser beam surgery performed with colposcopic guidance would seem to be ideally suited from several standpoints for the treatment of this sexually transmitted disorder. The precision of treatment affords destruction of the lesion with preservation of normal tissue, and the high temperatures that result in cellular evaporation may also destroy the local infecting agent. Alteration of the nerve ending results in immediate alleviation of pain. Most patients experience a marked decrease in condylomata-associated discomfort almost as soon as the procedure has been completed. There is virtually no scarring with this treatment, because the operator can control the depth of destruction. Healing is rapid, and infection is minimal, because the laser beam contacts affected tissue only. The thermal energy of the laser beam does not penetrate as deeply as electrosurgery or cryotherapy. According to Hahn,[4] it probably only penetrates to a limit of 800 microns. Furthermore, the small light beam can reach otherwise inaccessible areas by using mirrors to direct the beam, and the procedure is virtually bloodless.

The physics and mechanism of action of the CO_2 laser have been well documented and described in detail by Bellina,[5-7] Baggish,[8] Hahn,[9] Burrell,[10] Cibley,[11] and Polanyi.[12] The word "laser" is an acronym for Light Amplification by Stimulated Emission of Radiation. Lasers do not amplify light in a strict sense, however, but generate light with certain particular characteristics that engineers and scientists find useful. The inclusion of the term radiation is confusing, since a medical laser has no ionizing, x-ray, or harmful radioactive properties. It should be noted that its important clinical applications in gynecology are based on light intensity. Familiarity with the use of a colposcope is a prerequisite for gynecologic laser therapy. The colposcope allows the operator to see small lesions which might easily be missed or overlooked by the naked eye.

Materials and Methods

A Coherent Radiation model 400 CO_2 laser coupled with a Zeiss OpMi6 operating colposcope, which has a 400-mm. objective lens, was used in this study. This laser delivers monochromatic, collimated light with a wave length of 10.6 microns (infrared), and the laser beam converges at the focal distance to a "spot" having a measured diameter of 2 mm. A second laser, operating coincidentally and aligned with the invisible CO_2 laser, delivers a red helium neon aiming beam, which serves as a colored target indicator. Therapy was carried out at power densities of 300 to 1,250 watts/cm^2, depending on the depth of destruction desired.

Familiarity with the use of a colposcope is a prerequisite for gynecologic laser therapy.

Twenty-five patients with a diagnosis of condylomata acuminata were referred for treatment from August, 1978, to April, 1982. The ages ranged from 18 to 47 and comprised four teenagers, 13 women in their 20s, four in their 30s, and four in their 40s. Three patients were black, and 21 were white. Eight patients had had prior treatment with applications of podophyllum before referral: five had been treated more than once, and one had been treated 28 times. Three in the group had prior cryosurgery, and two of these had multiple treatments. Two patients had prior electrocautery, one patient had had surgical excision, and one patient had used 5-FU on two occasions. Therefore, any bias would be toward more difficult cases directed for laser beam management. Fourteen patients were classified as having limited disease with sites of involvement as follows: cervix 7, cervix and vagina 2, vagina 2, vulva 3. Eleven patients had extensive disease, where vulva, anus, perianal, urethral, vaginal, and cervical disease was evident. Fifty-two percent of the patients (13) had cervical condylomata. No anesthesia was required for cervical and vaginal condylomata. Local infiltration with 1% lidocaine was used for five patients with vulvar lesions, and nine patients required general anesthesia for extensive disease.

Strict instructions were given in regard to local hygiene and the temporary avoidance of sexual relations. Daily sitz baths were suggested, and douching or cleansing the area of treatment twice daily with a solution using equal parts of hydrogen peroxide and water for 7 to 10 days following treatment and the use of a hair dryer in the genital area were advised. Associated cervicovaginal infections were treated appropriately with specific drugs to control *Hemophilus, Chlamydia,* or *Trichomonas* infestation when encountered. Depending on the extent of treatment, patients were seen at 1 to 3 weeks after treatment and at 3, 6, and 12-month intervals thereafter.

Results

Possible complications include edema, bleeding, pain, infection, and scar formation. To date, no bothersome complications have occurred. Followup is available on all patients and ranges from 3 months

to 3½ years. Sixteen of 25 patients (64%) responded to a single laser treatment in which all visible lesions were eradicated and have not recurred. At 3 weeks after treatment, two patients had persistent lesions. Both had their lesions removed under local anesthesia, and then remained free of disease. Seven patients had recurrences at 4, 5, 7, 9, 14, 14, and 22 months. All seven patients consented to retreatment and in six, the lesions did not recur. The only patient to have two recurrences was also receiving steroids and an immunosuppressive agent for lupus erythematosis. Her first recurrence was at 14 months and her second recurrence was at 27 months after the initial laser surgery. She is currently 8 months since her last treatment and free of any lesions. At the time of this writing, all patients in this series are free of condylomata.

Compulsive referral of male partners for penile examination and elimination of their warts is essential in eradicating the disease. The failure of consorts to follow this advice was felt to be the major reason for the recurrences noted in this series.

Discussion

Verrucous carcinoma shows some histologic similarities to the more common filiform and sessile varieties of genital warts, which has caused this lesion to be confused with the benign condyloma acuminatum. Powell[13] published a review of verrucous carcinomas of the female genital tract in 1978 and emphasized that true verrucous carcinoma in the genital area can be distinguished from condyloma by the absence of a central connective tissue support in the papillary processes of a verrucous carcinoma. In addition, the condyloma is usually multifocal and occurs in young patients, while the verrucous carcinoma is unifocal and usually afflicts elderly patients.

At the time of this writing, all patients in this series are free of condylomata.

Large biopsies including adequate stroma are essential for diagnosis, but the clinical presentation may be as important in suggesting the correct diagnosis as is the histology. Furthermore, condylomata are a common public health problem, while verrucous carcinomas of the female genital tract are extremely rare. Only 45 cases of verrucous carcinoma of the female genital tract have been published.[13, 14] The site of involvement of these 45 cases was cervix in 15, vagina in 10, vulva in 17, and both cervix and vagina in 3. I have treated one additional case of verrucous carcinoma of the vulva in a 93-year-old patient since my earlier review of the literature.[13]

Eight of the patients (33%) in this series had atypical cervical or vaginal cytology associated with condylomata acuminata. The Papanicolaou smears ranged from mild atypia to carcinoma in-situ. Biopsy confirmation was performed in each of the cases and revealed carcinoma in-situ of cervix in 1, severe dysplasia of cervix in 2, moderate dysplasia of cervix in 4, and mild dysplasia of vagina in 1. One patient had a conization of the cervix 6 years before for severe dysplasia of the cervix. One patient had radiation therapy 8 years previously for invasive cervical carcinoma, and one patient had a partial vulvectomy for Bowen's disease of the vulva 2 years before laser therapy. These findings and epidemiologic evidence reported by Meisels[15] suggest a relationship between the wart virus and the etiology of the so-called multiple primary squamoid neoplasia of the lower genital tract.

In conclusion, CO_2 surgery, with its precision under colposcopic guidance, preservation of normal tissue, probable viral destruction, minimal scarring and blood loss, and rapid healing has proved to be a most satisfactory procedure for the control of condylomata acuminata.

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An example of a patient who might otherwise be considered too debilitated to derive benefit from exercise training yet who showed a substantial improvement in functional capacity.

A Modified Exercise Prescription for a Patient with Severe COPD

DONALD F. MAY, M.Ed., R.R.T., SUSAN P. PILBEAM, M.S., R.R.T., and WILLIAM R. KENNY, M.D., *Atlanta

Abstract

A 53-year-old man with severe emphysema was referred to a pulmonary rehabilitation program. He was evaluated with an exercise stress test to establish baseline data and to assess his functional capacity. The initial test results showed a maximum exhaled minute ventilation ($\dot{V}_E$) of 35 liters per minute, a maximum oxygen consumption ($\dot{V}O_2$) of .88 liters per minute, and a maximum heart rate of 125 beats per minute. Based on this data, an exercise program was developed consisting of exercise on a treadmill three times per week for 6 weeks. The patient's exercise tolerance improved from 10 minutes of walking at 1.25 MPH, 0% grade before training, to 25 minutes of walking at 1.5 MPH, 4% grade after training. Final exercise test results showed a maximum $\dot{V}_E$ of 38.5 liters per minute, a maximum $\dot{V}O_2$ of 1.0 liters per minute, and a maximum heart rate of 130 beats per minute. He is presented as an example of a patient who might otherwise be considered too debilitated to derive benefit from exercise training yet who showed a substantial improvement in functional capacity.

Introduction

Exercise testing and training programs for patients with chronic obstructive lung disease (COPD) are still very new. While the level of training required to achieve an improvement in fitness for normal subjects is well established, the minimum level of exercise necessary for training an individual with COPD has not been clearly identified. Comprehensive rehabilitation programs have been established at a number of medical centers throughout the country. Exercise training is an integral part of these programs which have been shown to reduce hospitalizations and lengths of stay for individuals with COPD.[1]

We present the following case study of a patient with severe emphysema who initially had a very low level of daily activity. His pulmonary function values were so low that typically it would have been felt he had no potential for rehabilitation. His eager participation in the exercise rehabilitation program and his diligent self-application to his own pulmonary care produced significant improvement in his functional capacity and lifestyle.

Case Report

A 53-year-old male with a history of severe emphysema was admitted to the exercise rehabilitation program at Piedmont Hospital in Atlanta. He had a 35-year history of smoking a pack of cigarettes daily. He complained of shortness of breath after walking one block at a normal pace. Daily activities were limited to a few household chores and occasional outings.

The chest X-ray showed an emphysematous configuration with flattened diaphragms, a generalized loss of vascular markings, and a small heart. Room air arterial blood gases were pH 7.48, $PaCO_2$ 41 mmHg, PaO_2 63 mmHg. The pulmonary function studies showed an FEV_1 of .68 liters per second, 19% of predicted, a FVC of 2.6 liters, 51% of

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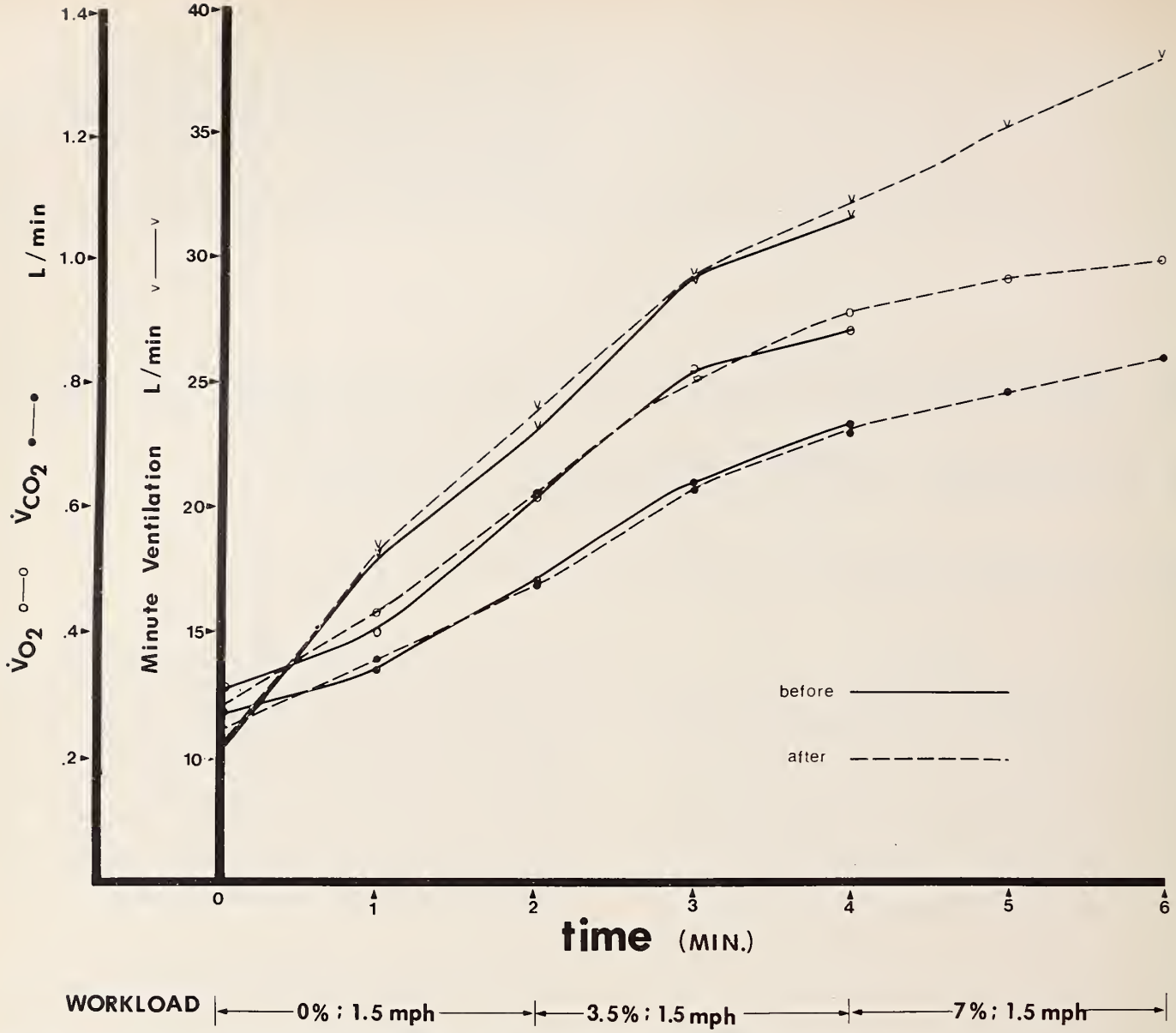


Figure 1 — Results of the exercise test(s) before and after training, showing minute ventilation ($\dot{V}_E$), oxygen consumption ($\dot{V}O_2$), and carbon dioxide production ($\dot{V}CO_2$) in relation to workload and duration of exercise test.

predicted, and FEF_{25-75} of .24 liters per second. Other values were similarly reduced, including a DLCO of 6.7 ml/mmHg/min (38% of predicted).

Using the Armstrong-Workman nomogram, the predicted value for maximum $\dot{V}O_2$ for a normal 53-year-old male is 2.3 liters per minute; for this patient with COPD, it was .8 liters per minute.[2]

The patient was evaluated with an exercise stress test for three reasons: first, to establish baseline physiologic data from which to determine a training program; second, to classify his functional capacity and to counsel him regarding occupational and leisure activities; and third, to evaluate him for cardiovascular disease.

In performing the exercise test, the following protocol was used: a 1.5 mile per hour constant speed, a starting grade of .5 percent, and an increase of 3 percent grade every 2 minutes. The results from the initial test showed that the patient was able to achieve a maximum workload of 1.5 miles per hour at 3.5 percent grade. His maximum achieved $\dot{V}O_2$ was .88 liters per minute. His maximum achieved heart rate was 125 beats per minute (75 percent of predicted maximum for his age), and his maximum achieved ventilation was 35 l/m or 166% of his resting MVV. The values for heart rate, $\dot{V}O_2$, $\dot{V}CO_2$, and $\dot{V}_E$, were graphed against workload (Figure 1). He was unable to achieve the anaerobic threshold, where production of CO_2 exceeds O_2 consumption (RQ > 1.0).[3] Because he achieved neither his maximum predicted heart rate (167) nor an anaerobic threshold, it was felt the patient's lung disease was the primary limitation to activity.

A rehabilitation program was started, with the patient exercising at 85 to 90 percent of his maximum achieved $\dot{V}O_2$. His corresponding heart rate was in the 115-120 range, while his minute ventilation during exercise was 78% of the achieved max-

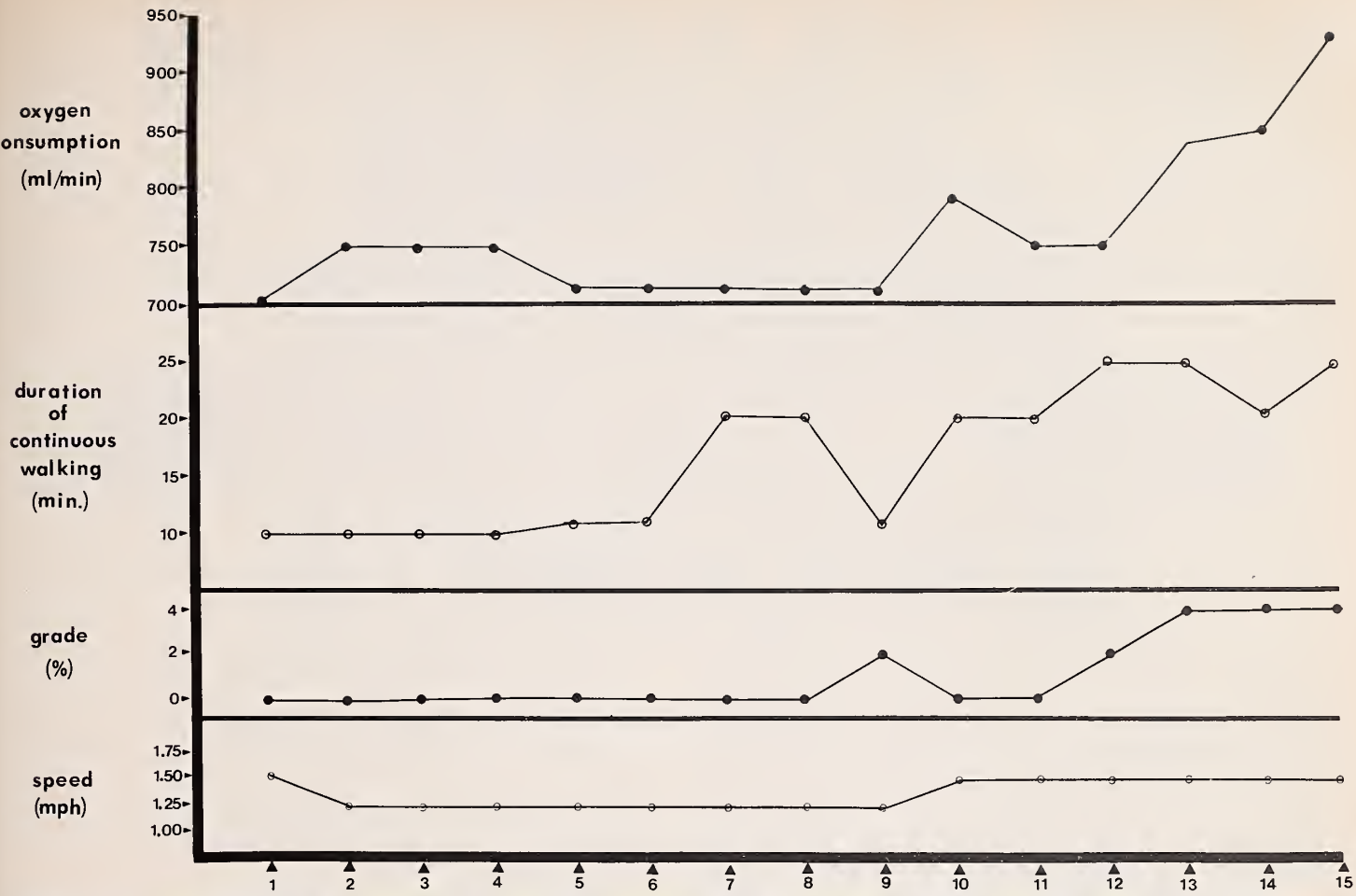


Figure 2 — Measurements of duration of continuous walking and achieved oxygen consumption (achieved $\dot{V}O_2$) during successive exercise sessions of the training program.

imum. His exercise consisted of walking on a treadmill three times per week for a minimum of 20 minutes as well as walking at home daily to achieve this target heart rate. He performed at this level with slight shortness of breath and with no fatigue. We desired a level of intensity near 90 percent of the tested $\dot{V}_E$ and $\dot{V}O_2$ and within the heart rate range 116-132. While this is a very high level of training, by sustaining his ventilation at this level we hoped to improve his ventilatory muscle function in addition to training his cardiac and peripheral vascular systems.[4] The patient was continued on his regular regimen of aerosolized isoetharine (Bronkosol), oral turbutaline (Brethine), and oral theophylline (Theo-Dur). The entire rehabilitation program including education, counseling, breathing retraining, and so on, was formally conducted for 6 weeks, after which the patient was retested and then encouraged to continue exercising on his own.

Results

Initially, it was necessary to divide the training sessions into several 5 to 7 minute intervals in order to achieve a total of 20 minutes. By the end of the rehabilitation program, he was able to continue for 25 minutes without stopping to rest (Figure 2).

On his final exercise test, he was able to achieve a workload of 1.5 miles per hour at 7 percent grade ($\dot{V}O_2$ = 1.0 liters per minute) and a heart rate of 130 BPM. His maximum achieved ventilation was 38.5 liters per minute, or 183% of his MVV. The anaerobic threshold, however, was still not achieved. His end point in the testing for both his first test and his follow-up test was due to fatigue, shortness of breath, and an elevated diastolic blood pressure.

Subjectively, the patient stated that he was walking farther at home than he had in months, with less shortness of breath. He was carrying out more activities of daily living with less fatigue and had taken a part-time job. His mental attitude and sense of well being had significantly improved.

Discussion

The determination of exercise tolerance through stress testing can be useful in the evaluation of how efficiently an individual performs physical exertion and in the formulation of an exercise prescription for training. Resting pulmonary function tests are of little value in either of these two areas. The combined use of pulmonary function and graded exercise testing seems to offer greater understanding of a

person's disease and degree of disability than either does alone.

During testing, in order to determine when a subject is approaching his maximum capacity, one looks for them to reach their predicted maximum heart rate. Frequently, in testing patients with chronic lung disease, the patient will stop the test well in advance of predicted maximum heart rate values. Generally, this premature maximum will occur due to dyspnea, ventilatory limitation, local muscle fatigue, fear, or cardiovascular abnormalities. Thus, the maximum for these individuals becomes the maximum achievable value.

An exercise prescription includes three criteria: intensity, duration, and frequency.

An exercise prescription includes three criteria: intensity, duration, and frequency.[5] Intensity is a heart rate range of 60 to 90 percent of the maximum age-predicted heart rate. Duration is a minimum of 20 minutes of activity in this heart rate range. Frequency is performance of the activity a minimum of three times a week, usually every other day. In this program, we begin training patients at 70 to 85 percent of the maximum achieved heart rate, 60 to 80 percent of the tested maximum $\dot{V}O_2$, or 60 to 80 percent of the maximum achieved $\dot{V}_E$, whichever is greater and best tolerated. This level of exertion is to be for 20 minutes and at least three times a week.[6, 7] It is important to continually obtain subjective assessments by the patient both during testing and training. The manifestations of fatigue, sore muscles, and other complaints should be noted along with objective criteria such as heart rate, respiratory rate, and blood pressure.

In this particular patient, the maximum achieved heart rate of 125 was 70% of his predicted maximum heart rate. His training heart rate range of 110 to 120 was 88 to 96 percent of his maximum achieved heart rate. Training at more than 90 percent of maximum is difficult even for normal subjects and can make training a very unpleasant experience. This patient was able to achieve the target heart rate with some shortness of breath and transient fatigue but few other complaints. The patient was constantly encouraged to tolerate the shortness of breath brought on by the exercise. His desensitization to the feeling of dyspnea probably contributed to his increased endurance. The monitored training sessions performed in the laboratory allowed us to safely push him past his usual stopping point of dyspnea.

While $\dot{V}O_2$ and maximum achieved workload did not increase greatly, the patient's ability to sustain a submaximum level of stress for a longer period of time did improve substantially. In terms of daily living, this would allow him to perform daily activities at this submaximum level for longer periods without experiencing exhaustion.

In a recent study, a group of COPD patients was instructed to sustain a high rate and depth of ventilation, maximum sustained ventilation (MSV), for a 15-minute period (isocapnic hyperpnea).[4] A rate and depth of ventilation was chosen to achieve at least 60 to 80 percent of the patient's resting MVV. This level of ventilation was repeated on a regular basis in the hope of training the ventilatory muscles. The patients in this study did demonstrate an improvement in endurance after MSV training. Perhaps the improved performance seen with our particular subject resulted from improvement in ventilatory muscle performance as well as overall conditioning.

A prescribed program of walking which elicits the level of ventilation found effective in a MSV program might be an effective and appropriate means of training COPD patients. A walking program allows the patient to exercise in a normal activity requiring no special equipment, and it is one that he can perform on his own. This level of exercise may improve endurance even though the heart rate during the activity may be below the intensity desired for a training effect.

Patient selection criteria for an exercise rehabilitation program should never exclusively select "out" any individual. A minimum resting pulmonary function value, i.e. FEV_1, or a maximum achievable $\dot{V}O_2$ below which no training can be achieved has not been clearly identified. Patients with significant disease processes, such as the one in this case study, can demonstrate improvement. Certainly the patient's attitude towards the program is important, but a negative attitude should not preclude the possibility of success. The patient's attitude might change as the exercise training begins to give positive results. Knowing the potential benefits, we optimistically continue to encourage any patient on a program of exercise rehabilitation. Additional studies are needed to consider the cost-benefit relationship of closely monitored exercise sessions in patients with COPD.

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WARNINGS

CARDIAC FAILURE: In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

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IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levarterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY: Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. *Central Nervous System:* lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory:* bronchospasm. *Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous:* reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings:* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

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Reference: 1. Freis, E.D. Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981.

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The Future of Nursing: Some Facts, Opportunities, and Challenges to Consider

JOHN E. SKANDALAKIS, M.D., *Atlanta**

I DO NOT KNOW of any other profession which is currently in a more transitional state than the nursing profession. The etiology behind this transition is threefold, having much to do with the women's movement, the move from hospital-based education to college settings, and the tremendous advances in biomedical technology, something which changes practically every year. For example, the nurse of today must know something about biochemistry (fluids and electrolytes), something about respiratory physiology (blood gases), and something about the heart (EKG changes).

The number of nurses in Georgia, and indeed across America, is presently about 20 percent short of what is needed. Hospitals especially feel the lack of nurses. The causes of this shortage are again multiple and include the fact that there are a great number of registered nurses who choose not to work because of inconvenient working hours (this is demonstrated by the fact that there are few vacancies in the field of community health nursing, which usually calls for an 8 to 5 o'clock, Monday through Friday schedule), poor wages, stress on the job, rotating shifts, and social commitments such as marriage, pregnancies, and raising children.

Another reason for the shortage of nurses is that many people considering this field are deterred by what can be called the "nursing complex." This is a fear of being treated as a glorified maid whose job is to do all the dirty work in the hospital (such as bed pan duty). This is an out-dated notion. Most people realize that the nurse of today must be considered a full member of the team, with full participation in helping the physician make the right decisions about a patient's care.

I feel that the women's movement is also partly responsible for the shortage of nurses. This movement has opened up new fields to women, giving them a greater choice as to what careers they are able to pursue. It is now entirely feasible for a woman to pursue a career in hitherto male-dominated professions such as law and medicine. For example, whereas enrollment in nursing schools is down, about one-third of students in medical schools are now women.

Finally, many people trained as nurses are choosing to go into administration and hospital management rather than working directly with patients.

The last few years have witnessed new avenues and new horizons opening up in the nursing profession. Today's nurses do not want just a nursing education, but desire a more well rounded background, such as in humanities, sociology, or psychology. The BSN degree, as well as the MS and Ph.D. in nursing, are results of this new trend.

Nursing education, as you know, may be accomplished by four programs: the licensed practical nurse, the associate degree in nursing, the hospital-based diploma (which I feel has a very definite place in nursing education), and baccalaureate programs. The last three produce the RN, while it is left to the masters and Ph.D. programs to produce the teachers and the administrators.

* Dr. Skandalakis is a general surgeon and a member of the Board of Regents of the University System of Georgia. This article is taken from a speech delivered to the School of Nursing of Kennesaw College on April 20, 1982. Send reprint requests to him at 35 Collier Rd., NW., Ste. 315, Atlanta, GA 30367.

The University System is very conscious of the need to encourage people to enter the nursing field by improving the quality of nursing education offered in Georgia. At the present time, 23 schools in the University System have nursing programs. Eighteen offer an ADN degree, eight offer a BSN, and two offer a MSN. It is to be hoped that within a few years the system will be able to offer a Ph.D. in nursing.

In the 1970s, a total of 11,000 nurses graduated in this state. As I have pointed out, however, there yet remains an acute need for many more nurses. The Board of Regents is trying to encourage people to enter the profession by establishing a nursing advisory board and strong communication between students and faculty, and by offering continuing nursing education through off-campus and weekend classes. Audiovisual education techniques are also being used. It is the Board's desire and intention to be able to offer nursing schools and degree programs of the finest quality possible.

Both doctor and nurse should strive to develop an ecumenical spirit, and above all, always be ready to support each other.

The February, 1982, issue of *Atlanta Medicine,* the official bulletin of the Medical Association of Atlanta, contains some very new and interesting statements. For example, a new compound alliance between professional nurses and physicians' assistants is proposed. The author does not have a name for this marriage, but it is a marriage which in my opinion is leading straight to divorce.

I hope you do not misunderstand me. I do not want you to think that I am against progress in the form of higher education for nurses. If a nurse wants to have a Ph.D. in nursing, the means of achieving this should be available to her. At the same time, however, with the need for nurses so acute, we must help anyone who wants an ADN to achieve this, no matter their age, sex, race, or marital status.

For a doctor and nurse to develop a good working relationship, it is necessary for the physician to offer the nurse friendship and understanding. The doctor must take steps to make the nurse a full member of the team by consulting with her and listening to her opinions. Although the relationship should be based on mutual respect, the doctor should always try to advise and teach. Mistakes should be corrected with a smile, and the nurse should be encouraged to be assertive. Both doctor and nurse should strive to develop an ecumenical spirit, and, above all, always be ready to support each other.

I recall the lines from Tennyson's poem "Ulysses," in which Ulysses, having conquered all of his known worlds, thinks back on all that he has done. He could easily be satisfied with his life, but he is eternally restless and curious. Talking with his men, he concludes the poem with these lines:

> Though much is taken, much abides; and though
> We are not now that strength which in old days
> Moved earth and heaven, that which we are, we are;
> One equal temper of heroic hearts,
> Made weak by time and fate, but strong in will
> To strive, to seek, to find, and not to yield.

Although I am not a Tennyson, I would like to change the last line a little:

> To strive, to seek, to find,
> And yield gracefully.

My point is that monolithic philosophy and militant ways will help neither the patient nor the health industry. It is the responsibility of everyone in the health professions to maintain a continuous dialogue and to develop an ecumenical spirit in order to be able to work together as a team to help the sick first and ourselves second. We must all be prepared to yield at times. Only by being willing to give and take are we able to help each other, and most importantly, to help the patient who needs our care.

And now permit me to close this address by reading to you what I said to the graduating nursing class of 1975,[1] when I was chief of staff at Piedmont Hospital.

"There is no question in my mind that a patient's best friend is his nurse. The nurse will stay with the patient when his family has gone home. The nurse will make the patient feel at home when he is friendless and homeless. One of my ancestors, Euripides, stated 'It's better to be sick than to nurse the sick. Sickness is a single trouble for the sufferers: but nursing means vexation of the mind and hard work for the hands, besides.' How right this great tragedian was! And we witness this every week in our hospital where durability of body and presence of mind are so essential for good patient care and many, many times, indeed, life-saving measures.

You don't know how grateful we are for your advice and suggestions. Sometimes our superficial egos do not show our appreciation, but be sure it is there.

The nurse cares equally for the poor or rich, the young or old, the famous or unknown, the ugly or beautiful. This reminds me of the story told of Ambroise Paré when King Charles IX told him to give him better care than he had given to the poor.

The great French surgeon answered, "I care for the poor as much as I care for kings."

And when death takes the patient in its embrace and his body is still warm on the hospital bed, the nurse will clean the bed, take care of the body, and take care of the family with a sad smile . . . a smile full of comfort and sympathy.

However, I want to emphasize something which I have recently observed. Many times nurses spend too much time with paperwork. Unfortunately, our changing era with all the medico-legal problems and agonies demands this paperwork. We all believe that our primary responsibility is to the patient. The great teacher of medicine, Sir William Osler, said, 'observe, record, tabulate, communicate.' This was written in 1919 and still stands today. However, I would say: treat the patient first and observe. Record and communicate your observations to the doctor. You don't know how grateful we are for your advice and suggestions. Sometimes our superficial egos do not show our appreciation, but be sure it is there.

I think that I have talked too much. I had better stop. Some of you will stay here in Georgia, while others will go — God only knows where. But please permit me to say to you an Irish wish that I love very much:

May the road rise up to meet you,
May the wind always be at your back.
May the sun always shine upon your face,
And the rains fall soft upon your fields.
And until we meet again . . .
May God hold you in the palm of his hand."

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The author discusses some of the many causes and treatment programs for these diseases.

Clinical Evaluation and Treatment of Interstitial Lung Diseases

GERALD W. STATON, JR., M.D., *Atlanta**

Interstitial lung disease (ILD) is a significant medical problem involving thousands of patients in Georgia each year. On many occasions, a chest radiograph is the only diagnostic procedure performed, failing to render a specific diagnosis. As a result, many patients with progressive, treatable inflammatory lung disorders may be denied life-saving therapy.

Patients with ILD may present in a number of ways, depending on the underlying disorder. Many will complain of dyspnea with or without a cough, usually nonproductive. There may be pleuritic chest pain, especially in those patients with sarcoidosis or ILD associated with a collagen vascular disorder (e.g., rheumatoid arthritis, systemic lupus erythematosus). Physical examination may reveal tachypnea, cyanosis, basilar rales, or signs of cor pulmonale. The chest radiograph may be interpreted as normal (in up to 20% of cases) or may show diffuse reticulonodular infiltrates that are frequently interpreted by radiologists as "pulmonary fibrosis" or "chronic lung disease." Pulmonary function testing may be relatively normal or may show evidence of a restrictive defect with decreased diffusing capacity and hypoxemia.

The clinician evaluating a patient with ILD is faced with a formidable diagnostic task. Inorganic and organic dusts, gases, fumes, vapors, and medications have been listed in a recent review as the most common causes for nearly 100 ILDs of "known etiology," in addition to nearly 30 ILDs for which the etiology is not known (e.g., sarcoidosis, ILD associated with collagen vascular disorders).[1] Most cases of ILD due to dust inhalation or medications can be diagnosed by patient history and a characteristic roentgenographic appearance; however, this accounts for only a minority of cases. Many of the remaining cases will require more extensive evaluation in order to establish a diagnosis. The diagnosis in some patients may require a test such as determination of the rheumatoid factor in ILD associated with rheumatoid arthritis, while in some cases an open lung biopsy may be required for diagnosis. Once the diagnosis is made, the clinician must determine the "activity" of the disease, since those with "active" inflammatory disease may need treatment and those with "inactive" disease need only close follow up.

Detailed studies (including lung biopsy) of large groups of patients with ILD have shown that some have active, ongoing inflammation in the alveolar structures of their lungs, i.e., an "alveolitis." It is this alveolitis that is the treatable precursor of the end-stage and untreatable fibrotic lung, and its intensity is the indicator of the need for treatment. This alveolitis is accompanied by an infiltration of inflammatory cells. Diseases such as sarcoidosis and hypersensitivity pneumonitis are characterized by accumulations of lymphocytes and monocytes (including alveolar macrophages), while diseases such as idiopathic pulmonary fibrosis, asbestosis, and possibly ILD associated with collagen vascular disorders are associated with accumulations of neutrophils and alveolar macrophages.[2] The numbers of inflammatory cells in the lung are felt to correlate with the activity of the disease and the intensity of the alveolitis.

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Unfortunately, simple studies such as history and physical examination, blood studies (erythrocyte sedimentation rate, etc.), chest radiograph, and pulmonary function tests do not accurately measure the intensity of alveolitis in two of the most common inflammatory ILDs, sarcoidosis and idiopathic pulmonary fibrosis (IPF).[1] Open lung biopsy obviously will give a true measure of the activity of the alveolitis but cannot be repeatedly performed during treatment or during follow up without treatment. In the last several years, however, gallium-67 lung scans and the inflammatory cell differential from bronchoalveolar lavage have been found to reflect the intensity of alveolitis.

Some patients with ILD have inflammatory lesions in their lungs, the activity of which can be determined by bronchoalveolar lavage and gallium-67 lung scans.

Bronchoalveolar lavage (BAL) is performed during fiberoptic bronchoscopy and involves repetitive irrigation of a lung segment or lobe with small volumes of normal saline. The retrieved fluid is examined for total cell count and differential of the inflammatory cells. Less than 1% neutrophils and less than 10% lymphocytes in the BAL fluid is considered normal.[5] Patients with sarcoidosis have an elevated percentage of lymphocytes, while patients with IPF have an increased percentage of neutrophils (Table 1). The distribution of cells in the BAL fluid correlates with the distribution of inflammatory cells in the lung tissue[2] and therefore is a measure of the intensity of alveolitis.

TABLE 1 — Bronchoalveolar Lavage Cell Differential in Normal Volunteers and Patients With Sarcoidosis and IPF[5]

	Normal Volunteers (n = 13)	*Sarcoidosis (n = 20)*	*IPF (n = 14)*
% Neutrophils	0.6 ± 0.2*	7.7 ± 2.1	31.4 ± 6.6
% Lymphocytes	9.7 ± 1.7	29.3 ± 4.4	8.2 ± 2.4
% Macrophages	89 ± 1.9	62.6 ± 4.8	52.8 ± 6.1

* ± SEM.

Gallium-67 lung scans have been used for years to localize occult abscesses and neoplasms and are now widely available. Normally, there is no uptake of gallium by the lungs;[1] thus, uptake by the lungs is a sensitive but nonspecific indicator of inflammation. The degree of uptake can be measured and correlates with the intensity of alveolitis in sarcoidosis and IPF.[3, 4]

Using these two techniques and dividing the patients into two groups consisting of those with high-intensity alveolitis and those with low-intensity alveolitis (Table 2), an assessment of the intensity of alveolitis in IPF and sarcoidosis can be made. The patients with IPF or sarcoidosis with high intensity alveolitis exhibit a high incidence of deterioration without treatment, while those with low intensity alveolitis show a low incidence of deterioration.[1]

Table 2 — Criteria for High-Intensity Alveolitis and Low-Intensity Alveolitis in IPF and Sarcoidosis[1]

Disease	*Test*	*High-Intensity Alveolitis*	*Low-Intensity Alveolitis*
IPF	BAL differential Gallium lung scan	>10% neutrophils and abnormal	<10% neutrophils or normal
Sarcoidosis	BAL differential Gallium lung scan	>35% lymphocytes and abnormal	<35% lymphocytes or normal

With this information, decisions regarding the need for treatment at the initial evaluation and the adequacy of treatment during follow up can be made based on direct measurements of the intensity of alveolitis. Other types of interstitial lung disease have not been studied well enough to know the role of these studies in their evaluation.

Treatment of the various types of ILD is dependent on the cause in the ILDs of known etiology and is dependent on the histologic type in the ILDs of unknown etiology.

Patients with ILD caused by exposure to external agents should certainly avoid further exposure. Many of these agents, such as most of the inorganic dusts and the gases, fumes, and vapors, are directly toxic to the lung and, as a result, do not respond well to treatment with anti-inflammatory agents such as steroids. In contrast, the organic dusts and some of the drugs induce an inflammatory pneumonitis that, when treatment is necessary, will respond well to steroids.

Among the ILDs of unknown etiology, sarcoidosis, chronic eosinophilic pneumonia, and some cases of IPF will respond to steroid therapy, though other cases of IPF require cytotoxic therapy. The ILDs that have a component of vasculitis, such as Wegener's granulomatosis, should be treated with cytotoxic therapy (usually cyclophosphamide) often in conjunction with steroids. Goodpasture's syndrome, which can occur without clinically apparent renal involvement and occasionally without hemoptysis, should be treated with plasmapheresis (to remove the anti-basement membrane antibody) and immunosuppressive therapy. Histiocytosis, idiopathic pulmonary hemosiderosis, and most of the chronic ILDs associated with the collagen vascular disorders do not respond well to treatment of any kind.

In summary, interstitial lung disease is a common problem with many possible causes. Some patients with ILD have inflammatory lesions in their lungs, the activity of which can be determined by bronchoalveolar lavage and gallium-67 lung scans. Once a diagnosis is established and the activity of the disease assessed, it is then possible to plan a rational treatment program. Though many of these diseases are treated with steroids, a specific diagnosis is required prior to institution of therapy.

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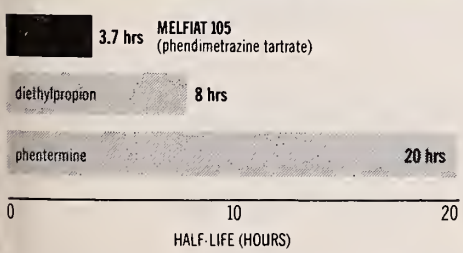


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WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

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USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.
Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
Allergic: Urticaria.
Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
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editorial
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MAG Leadership Conference

Organized medicine in Georgia has amassed an impressive group of dedicated physicians committed to the work of maintaining high quality medical care in a free enterprise environment. The tasks are enormous and the work tireless. But it is to some extent fragmented. The involved individuals include MAG officers, MAG board members, Auxiliary board members, committee chairmen and committee members, county medical society leaders, hospital staff officers, members of state regulatory boards, and officers of specialty societies. Frequently, one group is not aware of what the others are doing.

For this reason, at Callaway Gardens on November 12-14, MAG is planning to draw all of these groups together at its first Leadership Conference.

One of the main objectives is to develop an organization of hospital medical staff officers so that they can learn about and discuss problems and issues unique to them. It is expected that once organized, the medical staff officers will meet once or twice a year and seek special representation at the MAG Annual Session and at AMA meetings.

The Leadership Conference will feature formal presentations by national leaders on topics of critical interest to physicians, ranging from methods of cost containment and professional liability insurance problems to the new role of peer review organizations now that PSRO is being phased out.

Approximately 800-900 physician leaders will be invited to attend. The initial response has been good, and we expect good representation from around the state. With such a diverse group, which is not ordinarily afforded an opportunity to meet together, it is hoped that informal discussions in the halls, in the dining room, and on the golf course will supplement the formal talks and give those attending a broader perspective of the tremendous amount of work being accomplished by Georgia physicians.

We need to know what our cohorts in other areas of responsibility are doing. Come to Callaway Gardens in November and find out. With better coordination and better distribution of information about the varying activities, we can increase our effectiveness immeasurably. A great many of us are working for the cause of medicine in Georgia. Let's work together!

Charles D. Hollis, Jr., M.D.

heart page
heart page
heart page

Cardiovascular Consequences of Sleep Apnea

WILLIAM A. SPEIR, JR., M.D., and
BASHIR A. CHAUDHARY, M.D., *Augusta**

ALTHOUGH SLEEP APNEA may seem a curious and even droll subject for the "Heart Page," every practitioner should be aware of the profound cardiovascular consequences which often accompany sleep disturbances.

Sleep apnea syndromes have only been recognized in this country in the past 10 years. Initially, they were thought to be rare. It is now apparent, however, that sleep apnea syndromes and related sleep disturbances constitute a major, but often unrecognized, health problem.

The general features of sleep apnea syndromes have been extensively reviewed recently.[1] Briefly, apnea is cessation of airflow for at least 10 seconds. Apneic episodes during sleep are not uncommon in normal subjects, particularly men.

Over a period of years, many patients with sleep apnea syndrome develop fixed arterial blood gas abnormalities, systemic and/or pulmonary hypertension, cardiac arrhythmias, chronic cor pulmonale, and eventually, right ventricular failure.

However, normal subjects usually have less than one apneic period per hour of sleep. Patients with sleep apnea syndrome, on the other hand, usually have 10 or more apneic episodes per hour of sleep. Eighty percent or more of patients with the syndrome have obstructive sleep apnea, in which loss of muscle tone in the posterior pharynx and relapse of the tongue result in periodic upper airway occlusion during sleep. The episodes usually last from 10 to 100 seconds, although we have observed apneic periods of up to 210 seconds in our laboratory. During apneic episodes, profound arterial oxygen-hemoglobin desaturation may occur. Cardiac arrhythmias, usually bradyarrhythmias, are observed during the sleep apneic periods in 75 to 90 percent of patients and have been implicated in sudden death during sleep. Mild to moderate systemic hypertension, related to the repeated episodes of hypoxemia during sleep, occurs in approximately 50 percent of patients with the syndrome.

Transient pulmonary hypertension, in response to the periodic episodes of arterial oxygen desaturation, is the rule. However, over a period of years, many patients with sleep apnea syndrome gradually develop fixed arterial blood gas

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Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

abnormalities, pulmonary hypertension, chronic cor pulmonale, and eventually, right ventricular failure. Because obesity is common in patients with obstructive sleep apnea, these patients are usually considered "blue-bloating" chronic obstructive pulmonary disease (COPD) patients. However, they do not respond to standard therapy for COPD, and spirometry, when obtained, reveals normal expiratory flow rates, and a mild to moderate decrease in vital capacity due to obesity. It has been estimated that 5 to 20 percent of "blue-bloaters" have obstructive sleep apnea. In such cases, tracheostomy (to bypass the periodic upper airway occlusion during sleep) will prevent the intermittent episodes of profound hypoxemia, ameliorate the pulmonary hypertension, improve right ventricular function, greatly reduce the risk of sudden death from nocturnal cardiac arrhythmias, and often return the patient to a functional and productive life.

Sleep apnea has also been implicated as a cause of noncardiac pulmonary edema[2] and as a possible etiology of sudden infant death syndrome. Moderate alcohol intake[3] has been shown to increase the number of apneic episodes during sleep in normal subjects. Thus, while moderate alcohol intake increases levels of high density lipoproteins and may exert a protective effect against myocardial infarction, the risk of nocturnal cardiac arrhythmias and sudden death during sleep may be increased.

Recently, nasal obstruction, such as might occur with allergic rhinitis or a bad cold, has been shown to result in a dramatic increase in sleep apneic episodes, with accompanying arterial oxygen desaturation, in young normal subjects.[4] This reinforces the perception that sudden death following posterior packing for severe nosebleeds is due to cardiac arrhythmias induced by hypoxemia during sleep apneic periods.

Lastly, it has been reported[5] that patients with severe COPD have a greatly increased number of apneic episodes during sleep. It is apparent that the frequent episodes of arterial oxygen desaturation in an already hypoxemic patient can lead to devastating cardiovascular consequences.

In summary, an ever increasing number of patients without intrinsic heart, lung, or blood vessel disease are prone to develop severe problems with systemic hypertension, cardiac arrhythmias, arterial blood gas abnormalities, pulmonary hypertension, chronic cor pulmonale, and right ventricular failure just because of a "simple" sleep disturbance . . . and patients with pre-existing heart and lung disease are at even greater risk. The real and pressing need for readily accessible referral sleep monitoring centers, therefore, seems amply justified.

Perhaps F. Scott Fitzgerald was wrong: maybe "to be in bed and sleep not" is, indeed, not one of the worst things.[6] Albeit . . . I think I'll have a hot toddy for my cold, which is completely obstructing my nose, and take a nice, long nap.

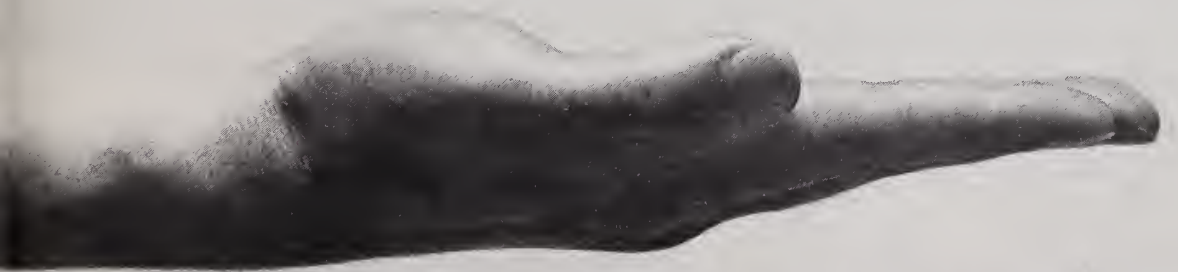
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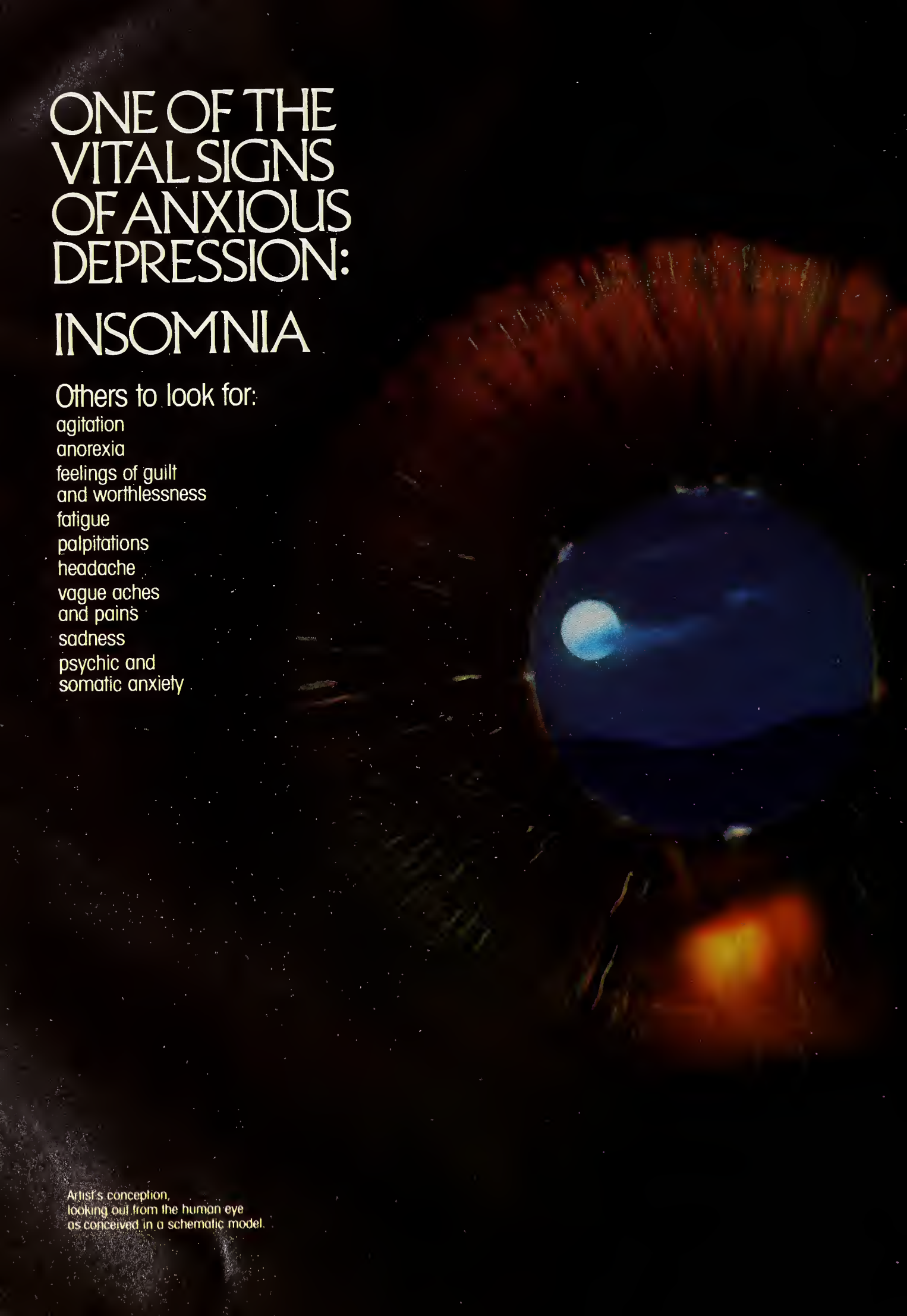
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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
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Antitrust Regulation of Health Care Professionals: Rapidly Moving Toward a Total Eclipse

ROBERT N. BERG, *Atlanta**

FOR MANY YEARS, it was believed that members of the "learned professions," such as physicians and attorneys, were exempt from attack under the antitrust laws. In 1975, however, the U.S. Supreme Court, in its landmark decision in *Goldfarb v. Virginia State Bar,*[1] expressly rejected the "learned profession" exemption, by holding that the bar association's minimum fee schedule constituted unlawful price-fixing under the federal antitrust laws. At the same time, the Court observed, in an often-cited footnote, that antitrust standards might be applied differently in connection with the activities of professionals, as opposed to ordinary commercial businesses, because of the "public service aspects and other features of the professions."

Following the *Goldfarb* decision, the shadow of antitrust regulation continued to expand to cover the activities of professionals. In 1978, the Supreme Court found that certain ethical restrictions against competitive bidding for engineering services imposed by a national engineering society constituted a violation of the antitrust laws.[2] In doing so, however, the Court also noted that, "by their nature, professional services may differ significantly from other business services, and, accordingly, the nature of the competition in such services may vary." This observation offered some degree of hope to professionals that the antitrust laws, while regulating their activities, might not be applied to those activities to the same extent or pursuant to the same analysis as was applied to other business activities.

Any such hope appears to have been significantly diminished, if not totally dashed, by the Supreme Court's recent decision in *Arizona v. Maricopa County Medical Society,*[3] in which an agreement among certain county medical associations and foundations for medical care to abide by maximum fee schedules was found to constitute a *per se* unlawful price-fixing agreement under the antitrust laws. Moreover, in another recent Supreme Court case, *Union Labor Life Insurance Co. v. Pireno,*[4] the Court held that peer review arrangements do not constitute the "business of insurance" and therefore are not exempt from antitrust scrutiny.

Applying the Antitrust Laws to Health Care Activities

In the *Maricopa County* case, the State of Arizona filed a lawsuit against two county medical societies and their non-profit foundations for medical care. The State alleged that the defendants had violated the antitrust laws by entering into an agreement pursuant to which the physician-members of the county medical

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

societies agreed to accept, as payment in full for services performed for patients insured under foundation-approved plans, no more than the maximum fees set forth in schedules established by those foundations.

Prior to trial, the State moved for partial summary judgment on the issue of liability, arguing that the defendants' activities constituted *per se* unlawful price-fixing agreements; as a result, the State's argument went, the existence of the agreement itself (a fact not in dispute) was sufficient to find an antitrust violation, and the trial court therefore did not need to analyze the actual competitive or anticompetitive effects of that agreement. The trial court disagreed, however, refusing to enter summary judgment for the State. Instead, it held that the challenged activity must be analyzed under the "rule of reason," which requires that the procompetitive and anticompetitive effects of the challenged activity be analyzed; only if the anticompetitive effects outweigh the procompetitive effects does the agreement constitute a violation of the antitrust laws.[5]

. . . it seems clear that the "learned professions" exemption which was alive and well as late as 1975 is now quite dead, and that physicians and their associations, in contemplating actions, must give full and careful consideration to the potential consequences should those activities be found to violate the antitrust laws.

The primary basis for the trial court's decision was that the health care industry was sufficiently different from other traditional business areas so as to require a full-blown analysis of the procompetitive and anticompetitive aspects of the arrangement, regardless of the fact that similar arrangements, in traditional commercial business settings, constituted *per se* unlawful activities under the antitrust laws. On appeal, the Ninth Circuit Court of Appeals agreed, holding by a 2-to-1 margin that the appropriate antitrust analysis was one in which the purpose and effect of the arrangement was considered.

The decision was then appealed by the State to the Supreme Court, which held, by a 4-to-3 margin (Justices Blackmun and O'Connor taking no part in the consideration or decision of the case), that the arrangement constituted *per se* unlawful price-fixing. Initially, the Court noted that, "horizontal agreements to fix maximum prices [are] on the same legal — even if not economic — footing as agreements to fix minimum or uniform prices." Thus, the arrangement between the county medical societies and foundations for medical care could not be excused on the ground that it dealt with maximum, rather than minimum, fees.

The Court also rejected the defendants' argument that the arrangement could not be found to be illegal without a detailed analysis of the procompetitive and anticompetitive effects of the arrangement. According to the Court, "[T]he anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some." Thus, the Court found the arrangement to constitute *per se* unlawful price-fixing in violation of the antitrust laws.

Narrowing the Exemption for the "Business of Insurance"

Ten days after its decision in *Maricopa County,* the Supreme Court rendered its decision in the *Pireno* case. In *Pireno,* a chiropractor brought an action against an insurance company and a state association of chiropractors, alleging that the defendants had conspired to fix the prices for chiropractic services in violation of the antitrust laws. The thrust of the chiropractor's allegations was that the peer review arrangement entered into by the defendants, pursuant to which the chiropractic association rendered opinions on the necessity of the treatments and the reasonableness of the charges made by chiropractors, in actuality was an unlawful

price-fixing agreement. The defendants countered these allegations by claiming that the peer review arrangement constituted the "business of insurance" and therefore was exempt from antitrust attack under the provisions of the McCarran-Ferguson Act.[6]

The trial court agreed that the peer review arrangement constituted a part of the "business of insurance" and dismissed the chiropractor's lawsuit. On appeal, the Second Circuit Court of Appeals reversed, finding that the "business of insurance" exemption should be strictly construed and, as a result, did not extend to peer review arrangements.

The Supreme Court, by a vote of 6-to-3, concurred with the Court of Appeals that the peer review arrangement between the defendants did not constitute the "business of insurance" and therefore was not exempt from antitrust attack. In the Court's view, the peer review arrangement neither served to transfer or spread the policyholder's risks, nor was it an integral part of the policy relationship between the insurer and the insured. Moreover, the Court deemed it to be significant that the practice of peer review was not limited to entities within the insurance industry; rather, to the Court, peer review was at best ancillary to the claims adjustment process.

The *Pireno* decision dealt only with the limited question of whether or not peer review arrangements between insurance companies and peer review organizations are exempt from antitrust attack. The Court expressly stated that "in deciding this case, we have no occasion to address the merits of [the chiropractor's] Sherman Act claims." Thus, the *Pireno* decision theoretically was not intended to have a substantive effect on the issue of whether or not peer review arrangements constitute unlawful agreements under the antitrust laws. However, as pointed out by Justice Rehnquist in his dissenting opinion, "there can be little doubt that [the *Pireno* decision] will vastly curtail the peer review process. Few professionals or companies will be willing to expose themselves to possible antitrust liability through such activity."[7]

Future Application of the Antitrust Laws to Activities Undertaken by Health Care Professionals

The *Maricopa County* and *Pireno* cases, viewed together, are a double-edge sword in analyzing the future applicability of the antitrust laws to activities undertaken by health care professionals. The *Maricopa County* decision, realistically, must be viewed as an expansion by the Supreme Court of the scope of antitrust regulation over health care activities. Construed broadly, the decision may be interpreted to mean that, for purposes of the antitrust laws, the health care industry is no different from any other business. Even construed more narrowly, the Court's opinion clearly prohibits one or more groups of competing physicians from agreeing or conspiring to set the prices at which they will render health care services, even if the agreement deals with maximum fees and is in line with the "cost containment" goals of the present administration and Congress.

While the *Maricopa County* case expands antitrust scrutiny over health care activities, the *Pireno* case serves the same function but from a different perspective: it narrows the statutory exemption that might allow certain health care activities to escape antitrust scrutiny. Although, as indicated above, the Supreme Court expressly refrained from commenting on the merits of the particular peer review arrangement involved, it is nonetheless likely, as noted by Justice Rehnquist in his dissent, that there will be a decrease in the number of peer review arrangements entered into by medical societies, foundations for medical care, and their physician-members. Moreover, there is likely to be an increase in the number of antitrust challenges to peer review arrangements, since plaintiffs will be able to reach the merits of their antitrust claims, rather than being subject to summary judgment on the grounds that the challenged activities are exempt from liability under the McCarran-Ferguson Act.

In total, it will be several years — during which lower courts will attempt to construe the *Maricopa County* and *Pireno* decisions and apply them to factual situations involving antitrust attacks to health care activities — before the actual effect of those decisions will be known. Nonetheless, it seems clear that the "learned professions" exemption which was alive and well as late as 1975 is now quite dead, and that physicians and their associations, in contemplating actions, must give full and careful consideration to the potential consequences should those activities be found to violate the antitrust laws.

Notes

1. 421 U.S. 773 (1975).
2. *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).
3. 50 U.S.L.W. 4687 (June 18, 1982).
4. 50 U.S.L.W. 4911 (June 28, 1982).
5. The distinction between the *per se* analysis and the "rule of reason" analysis is an important (and oftentimes critical) one. The "rule of reason" approach is the standard analysis utilized by courts in antitrust cases to determine whether an activity "unreasonably restrains trade"; it involves a detailed evaluation of the effects of the activity on competition, together with an analysis of the nature of the particular industry involved and the reasons and motivation of the person or persons engaging in the activity.

 However, some activities, such as price-fixing and group boycotts, because of their "pernicious effect on competition and lack of any redeeming virtue," are deemed by the courts to be *per se* unlawful. These activities are conclusively presumed to be illegal, without elaborate inquiry as to the precise harm they have caused or the business excuse for their use; the existence of the activity, standing alone, violates the antitrust laws. See, generally, *Northern Pacific Railway v. United States*, 356 U.S. 1 (1958).
6. 15 U.S.C. §§1011-1015.
7. 50 U.S.L.W. at 4916.



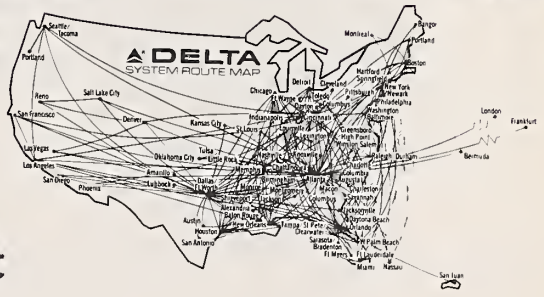


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president's letter



Another Medusa and Snail?

EMPLOYERS BEAR most of the cost for medical care — especially hospital care. And these costs have reached the point where they are an increasingly important item in the expense of doing business. In the past, the price for medical insurance has been accepted as an inevitable and uncontrollable factor, like utilities, in day-to-day operations. At present prices, however, the business community is taking a hard look at alternative approaches to providing medical care for employees. Prominent among these alternatives is the use of HMOs. Many of us in medicine feel HMOs are motivated toward non-delivery of care and are thus not desirable for our patients.

The quality and accessibility of care are of primary concern to physicians. Our training directs us toward this kind of thinking. To the businessman, trained in management, producing a product at a cost he can sell competitively is his primary objective. As a consequence, he is determined to find a way to finance medical benefits for his employees less expensively, with or without maintenance of the standards of care that we in medicine feel are essential.

Discussions will continue, and changes will be made. We physicians should assume our responsibility to participate in these discussions and to help devise ways to accomplish the basic purposes of medicine and business — i.e. find a way to provide medical benefits at a reasonable price without sacrificing quality and accessibility of care.

Some options to discuss might include the following:

1. Insist that insurance contracts include deductibles and copayments;
2. Include pre-admission testing and evaluation as part of hospital insurance coverage;
3. Offer financial incentives in contracts for surgery on an outpatient basis;
4. Increase coverage for outpatient evaluation and treatment for medical problems;
5. Encourage commercial companies to insist upon routine peer review by voluntary physician peer review organizations for their policy holders;
6. Solicit help from the Chamber of Commerce groups in developing effective tort reform, sparing the incalculable expense of unnecessary testing and hospitalization done solely to protect the practitioner against malpractice litigation.

Business managers have a problem. It is a problem with which we physicians have unique expertise and can offer constructive suggestions. We must take the initiative in meeting with our friends in the local business communities to form business-medicine coalitions, seeking to find solutions which will accrue benefits to business and to our patients. Like that between the Medusa and the snail, ours can be a mutually beneficial relationship. The MAG can accumulate information and act as a clearinghouse for the various groups interested in progress being made around the state.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.

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Caldwell, Lina B., DeKalb—ACT (N-1)—IM
755 Columbia Dr., Ste. 615, Decatur 30030

Chiang, Mike S., Tift—ACT (N-2)—U
1615 John Orr Dr., Tifton 31794

Delgado, Emilio, Randolph-Stewart-Terrell—ACT—GS
303 Johnson St., Dawson 31742

Deutsch, Anthony J., Crawford W. Long—ACT (N-2)—IM
740 Prince Ave., Athens 30601

Friedman, Michael A., DeKalb—ACT (N-2)—IM
755 Columbia Dr., Ste. 815, Decatur 30030

Graciaa, Guido F., Baldwin—ACT—N
912 Riverbend Rd., Milledgeville 31061

Hunt, John H., Georgia Medical—ACT—PTH
5205 Waters Ave., P.O. Box 23089, Savannah 31403

Hurteau, John E., Crawford W. Long—ACT (N-2)—PS
1010 Prince Ave., Athens 30605

Isshak, George, Newton-Rockdale—ACT (N-2)—GS
1359 Milstead Rd., Ste. 202, Conyers 30207

Kwok, Ken K., Spalding—ACT (N-2)—FP
Milby Medical Center, P.O. Box 561, Zebulon 30295

Long, Eugene M., Jr., Richmond—ACT—OBG
1810 Central Ave., Augusta 30904

Merrill, Clinton F., Emanuel—ACT—IM
105 Racetrack St., P.O. Box 630, Swainsboro 30401

Prince, Ronald B., Newton-Rockdale—ACT (N-2)—IM
4140 Tate St., Covington 30209

Robinson, Raleigh M., Crawford W. Long—ACT (N-2)—ORS
125 King Ave., Athens 30610

Traer, John W., Washington—ACT—GS
522 Washington Ave., Sandersville 31082

PERSONALS

First District

Dublin internist, **Robert D. Shuman, Jr., M.D.,** was elected to Fellowship in the American College of Physicians. A graduate of Johns Hopkins Medical School, Dr. Shuman is on the staff of the Fairview Park Hospital, and is a cardiology consultant to the Dublin VA Medical Center.

Fifth District

Mark A. Gould, M.D., Medical Director of Brawner Psychiatric Institute and Psychiatric Institute of Atlanta, was a guest panelist at "AHA '82 Atlanta" the 1982 Convention of the American Hospital Association held at the Georgia World Congress Center, August 30-31 and September 1. Dr. Gould discussed the specific role of the psychiatric hospital under the general topic, "Specialty Institutions: An Endangered Species?"

Spencer B. King, III, M.D., of Emory University School of Medicine, was chosen president-elect of the Georgia Affiliate of the American Heart Association for 1982-83.

Steven L. Morganstern, M.D., an Atlanta urologist, recently opened two new urology clinics in the Atlanta area.

Nanette K. Wenger, M.D., F.A.C.C., Professor of Medicine (Cardiology), Emory University School of Medicine and Director, Cardiac Clinics, Grady Memorial Hospital, Atlanta, was a member of the guest faculty for a seminar on myocardial infarction held in Memphis, TN, October 7-9. The seminar was sponsored by the American College of Cardiology (ACC), the University of Tennessee College of Medicine, and Baptist Memorial Hospital in Memphis.

Eighth District

Ricardo I. Zarzuela, Jr., M.D., a general practitioner in Waycross, recently opened a branch office in Blackshear. Dr. Zarzuela opened his practice in Waycross on Feb. 1, 1982.

Ninth District

Jayaprakash R. Desai, M.D., has moved his internal medicine-cardiology practice from Toccoa to Lawrenceville.

Tenth District

Lois T. Ellison, M.D., was elected the new president of the Georgia Affiliate of the American Heart Association for 1982-83. Dr. Ellison is a member of the faculty and administration of the Medical College of Georgia.

William A. Speir, Jr., M.D., a professor at the Medical College of Georgia, has received a grant to research high blood pressure in the lungs. The grant is funded by the Georgia Lung Association.

DEATHS

Abraham Herman Germain

Abraham Herman Germain, M.D., age 78, died July 28 in Atlanta. Dr. Germain graduated from Oglethorpe University in 1931, received an M.A. in psychology from Emory University in 1934 and his medical degree at the Medical College of Georgia in 1938. He was selected as Georgia's Physician of the Year in 1981 by the MAG. He served as the first medical secretary at Clayton General Hospital and was a member of the staff at Crawford W. Long and South Fulton Hospitals.

Survivors include his wife, one son, one sister, and four grandchildren.

Clarence R. A. Redmond

Clarence Revenel Avant Redmond, M.D., of Savannah, died July 30, at the age of 71. He received his medical degree from the Medical College of Georgia, and was a member of the Georgia Medical Society, the American Medical Association, and the Medical Association of Georgia.

Dr. Redmond is survived by his wife, two daughters, one son, and two grandchildren.



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- Measured against a propoxyphene-acetaminophen combination for pain relief after 3rd molar extractions, ibuprofen proved equally effective and caused fewer side effects. Ibuprofen was associated with faster recovery, evidenced by more rapid reduction of trismus and return to normal function.[3]
- Measured against post-episiotomy pain in 30 patients, "ibuprofen was effective in treating the swelling as well as pain...during the first and worst days. Therefore, it is not only the analgesic but also the anti-inflammatory effect of ibuprofen that are the beneficial factors..."[4]

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• better tolerated than aspirin	• combined side effects of two drugs—warning required about driving or operating machinery; possible respiratory depression with alcohol, tranquilizers, other common medications
• no narcotic risk, red tape, records	• narcotic precautions required
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References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases, 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: Canad Dent Assoc J 46:433-439, 1980.
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4. Taina E: Curr Med Res Opinion, 7:423-428, 1981.

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INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). Central Nervous System: dizziness*, headache, nervousness. Dermatologic: rash* (including maculopapular type), pruritus. Special Senses: tinnitus. Metabolic: decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. Central Nervous System: depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. Dermatologic: vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. *Special Senses:* hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) [see PRECAUTIONS]. Hematologic: neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. Cardiovascular: congestive heart failure in patients with marginal cardiac function, elevated blood pressure. Allergic: syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). Renal: acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. Miscellaneous: dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. Central Nervous System: paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. Dermatologic: toxic epidermal necrolysis, photoallergic skin reactions. Special Senses: conjunctivitis, diplopia, optic neuritis. Hematologic: bleeding episodes. Allergic: serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis. Endocrine: gynecomastia, hypoglycemia. Cardiovascular: arrhythmias (sinus tachycardia, bradycardia, and palpitations). Renal: renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. *Do not exceed 2,400 mg per day.*

CAUTION: Federal law prohibits dispensing without prescription.

Committee Activities . . .

Highlights of the August MAG Executive Committee Meeting

(At the August 22, 1982, MAG Executive Committee meeting, the chairmen of several committees reported on their committees' current activities and future plans. Presented below are summaries of those reports. Read them and become better informed about your Association.)

Health Planning: Tom Anderson, MD, Chairman of MAG's Health Planning Committee, presented six sections of the Georgia Health Planning and Development Agency's (SHPDA) proposed revision of the State Health Plan for review. The sections reviewed were: Prenatal Services, Health Education, CT Scanning Services, Occupational Health, Family Planning Services, and Primary Health Care Services. All recommendations by Dr. Anderson were approved with minor revisions except the Primary Health Care Section. The Executive Committee requested the Health Planning Committee to develop the essentials of an acceptable plan for consideration by SHPDA.

Cost Awareness: The Executive Committee voted to participate in the Greater Atlanta Coalition on Health Care since this coalition will have statewide impact. Funds, when needed, will be requested from the Board of Directors and/or included in subsequent budgets.

Dinner for New Legislators: The Executive Committee voted to recommend to the MAG Board that funds be allocated for a dinner for newly elected state legislators to be hosted by the MAG Committee on Legislation and by the Auxiliary.

Medical School Deans: In an effort to foster better communications between MAG and the medical schools, Dr. Charles Hollis, as president, reported on a meeting between himself and the deans. The Executive Committee agreed that it would be helpful for the deans to be invited to Executive Committee meetings on a regular basis.

Civilian-Military Contingency Hospital Plan: Dr. William Moore presented a report concerning the establishment of the Department of Defense's Civilian-Military Contingency Hospital System. This plan requests full service hospitals with 150 or more beds to agree to accept up to 50 military casualties each in the event of a conventional war. The hospitals will make their own commitments. The Executive Committee voted to endorse this plan.

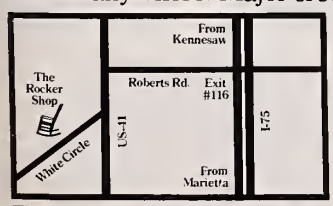
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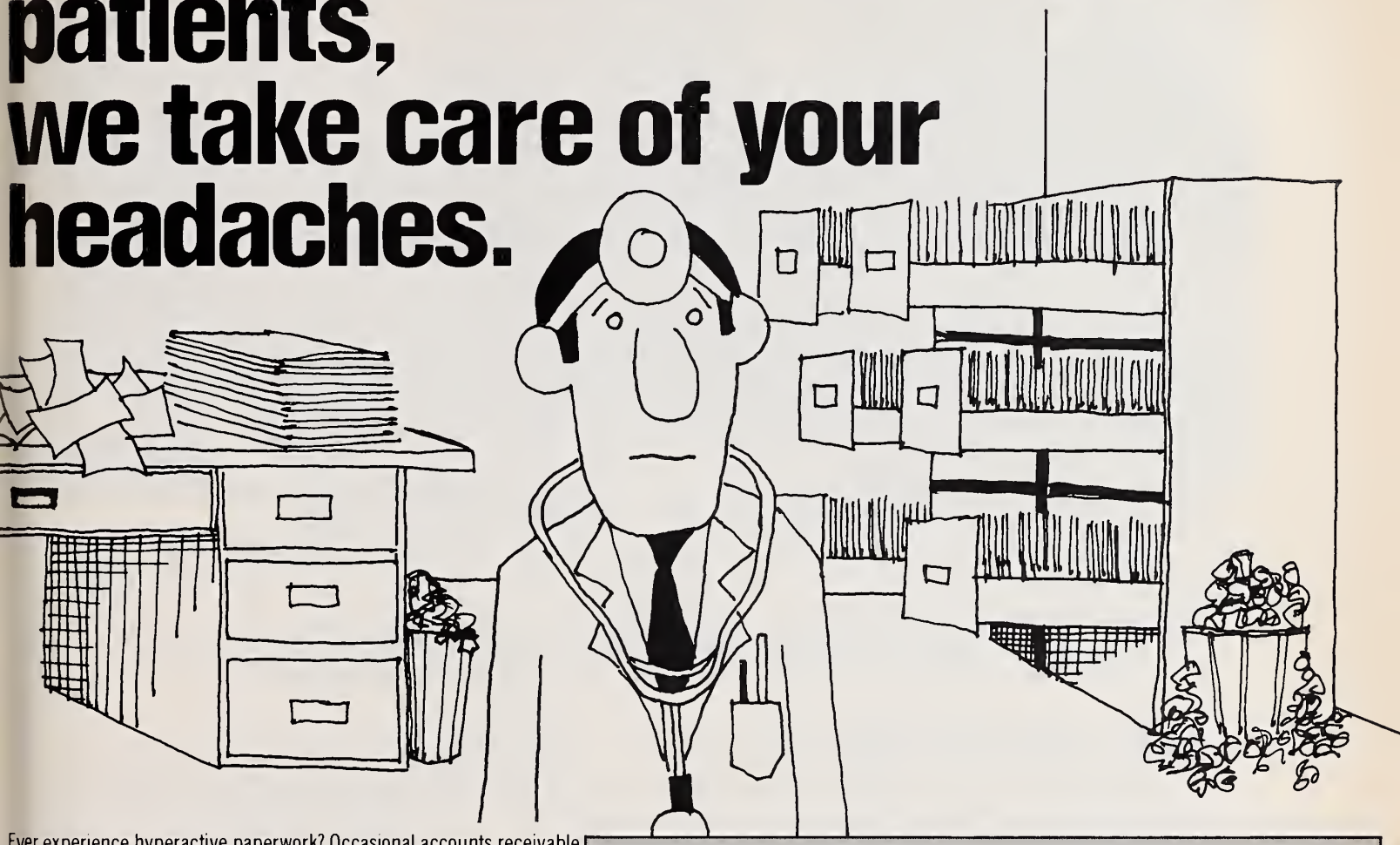
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In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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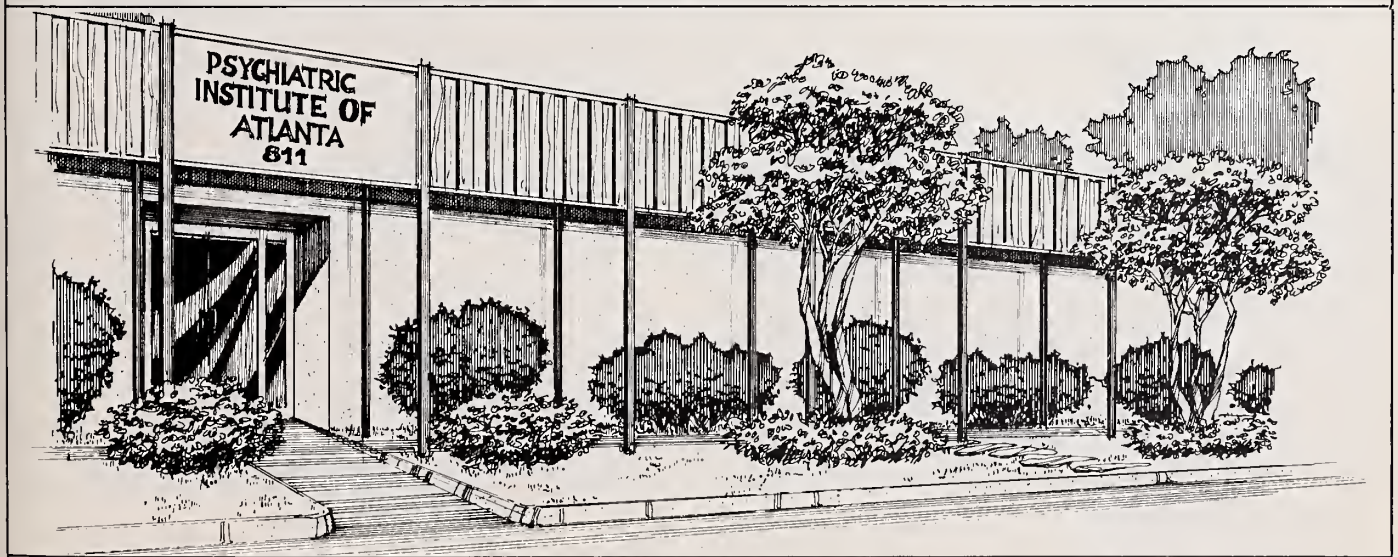
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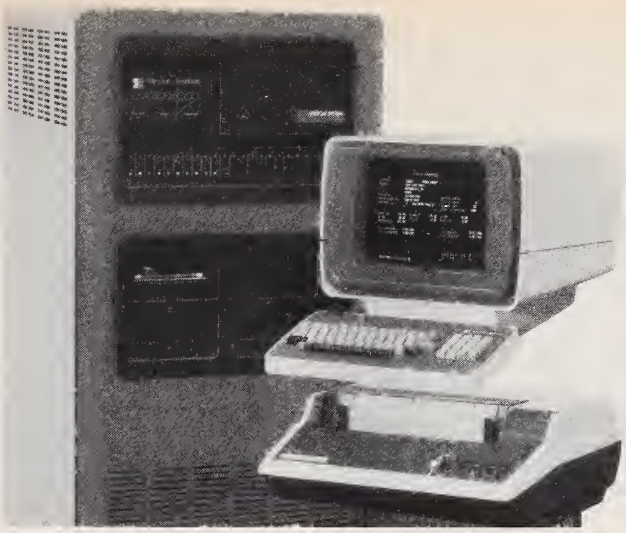
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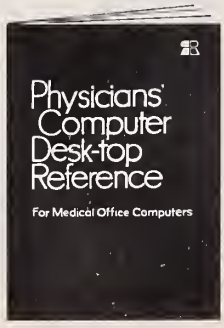
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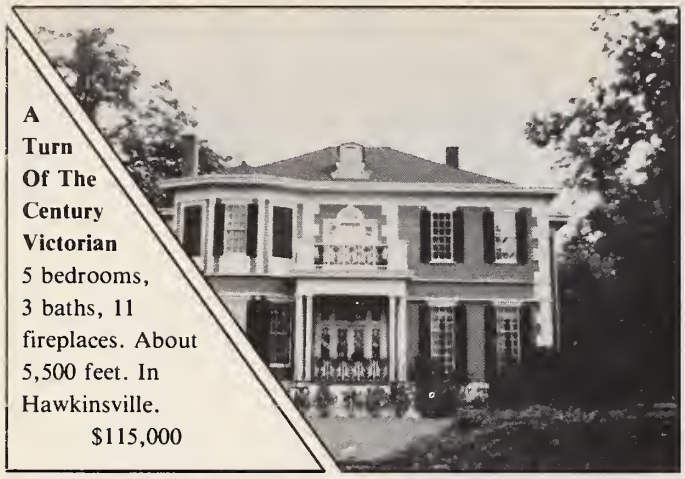


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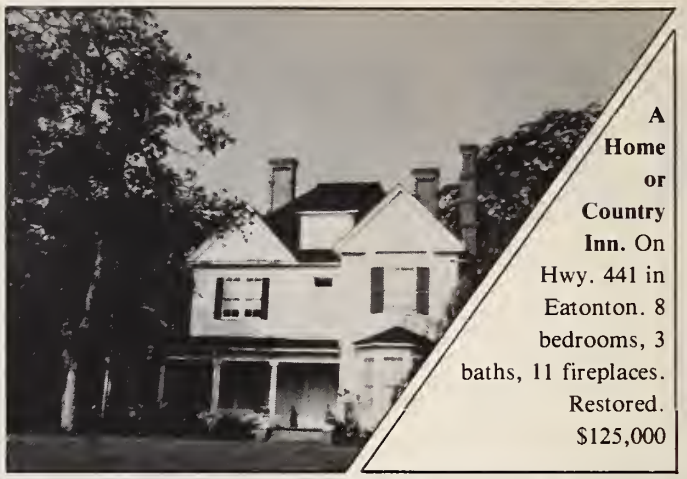
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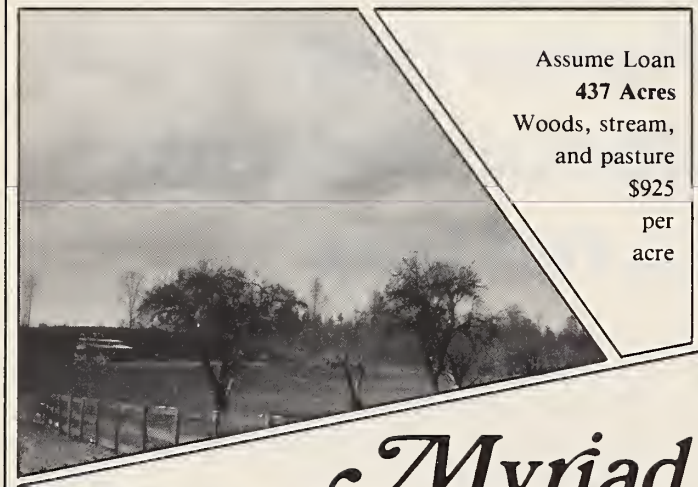
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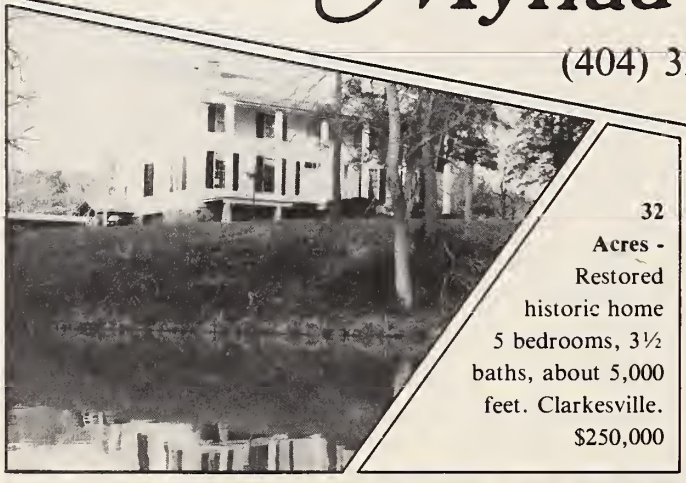
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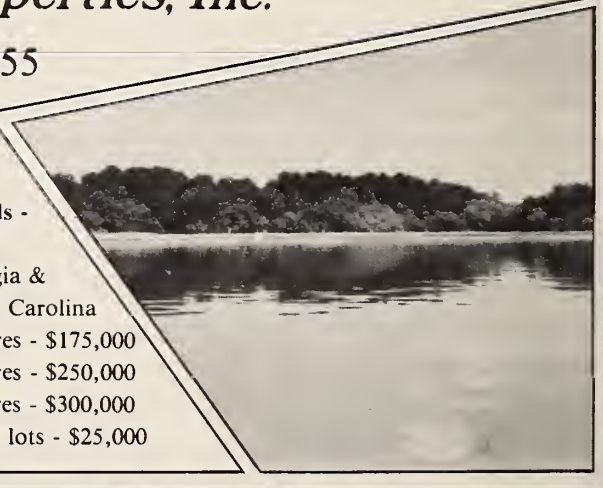
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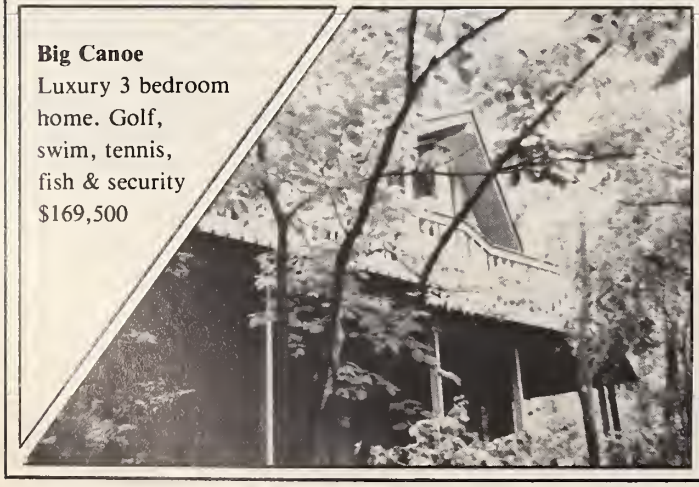


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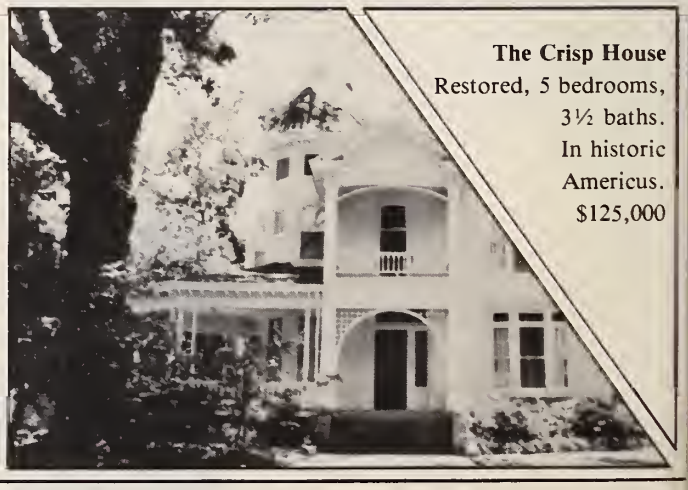
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Design by Kathy Honea, of Atlanta.

Incidental Intelligence . . .

The Department of Neurology at Emory Joins the National Study on Plasmapheresis and Acute Guillain Barré Syndrome

The Department of Neurology at Emory University School of Medicine has joined the national collaborative study to determine if plasma exchange has a positive effect on the course of acute Guillain Barré syndrome. Though plasma exchange appears to be of benefit in some chronic immune neuropathies, it has not been shown to be better than optimal supportive care for acute Guillain Barré. Rapid improvement and prolonged weakness have been noted in patients in both the treatment and non-treatment groups. The current study is the largest study that is likely to be done on this subject.

If your patient meets the criteria for diagnosis and wishes to participate in the study, he or she will be randomized to a treatment or non-treatment group after evaluation at Emory Hospital. Before agreeing to the referral, the patient and family should know that he/she cannot go to Emory guaranteed to get plasma exchange. A patient with acute Guillain Barré syndrome cannot receive plasma exchange at Emory unless he/she is in the study; and if entered into the study, there is a 50% chance that he/she will be randomized to the group that receives supportive care and no other treatment. Also, as there continues to be major disagreement in the literature about the role of steroids in acute Guillain Barré, patients cannot be given steroids and remain in the study. If steroids have been given, the dose must be reduced to 5 mgs. of Prednisone or less prior to randomization. Below are the criteria for diagnosis and exclusions.

Criteria for Diagnosis:

1. Progressive motor weakness of more than one limb.
2. Areflexia or marked hyporeflexia.
3. Cerebrospinal fluid cell counts of no more than 50 monocytes or 2 polymorphonuclear leukocytes.

Criteria for Exclusions:

1. Less than 12 years old.
2. Evidence for porphyria, diphtheria, lead or hexacarbon intoxication, polio, botulism, toxic neuropathy, organophosphate poisoning.
3. Severe unrelated medical disease which would make plasma exchange dangerous or which could limit short-term life expectancy.
4. Immunosuppressive medication or more than 5 mgs. of Prednisone per day.
5. Hepatitis B antigen positive.
6. Patient or family unable to give informed consent.

If you wish to refer a patient with acute Guillain Barré for inclusion in the study, call Mrs. Skehan, the local study coordinator, or Linton C. Hopkins, M.D., Principal Investigator, Guillain Barré study at Emory, 404-321-0111, ext. 3452.

Conference on Rural Primary Care Slated for March of '83

The Sixth National Conference on Rural Primary Care will be held in Kansas City, Missouri, March 6-9, 1983, at the Radisson-Muehlebach Hotel. Sponsored by the National Rural Primary Care Association, the conference is being co-sponsored by over a dozen national health-related organizations.

The NRPCA Conference Planning Committee has voted to extend the program to a full 3-day schedule of events for rural health care professionals. Working cooperatively with the conference hosts, the American Academy of Family Physicians, the national co-sponsoring organizations and local co-hosting groups, the Committee has planned a diverse and comprehensive educational program, along with organized recreational activities.

The workshop program, offering over 50 sessions, will include the following topics: health care marketing and management, rural hospitals, migrant health care, linkages, paraprofessional issues and emergency medical services. An excellent continuing education program is also being planned for physicians, nurses, NPs, PAs, and dentists.

A new component of the 1983 conference will be the Legislative Forum on Sunday afternoon, March 6.

For further information and/or registration forms, readers may contact Carrie Samuel, Conference Coordinator, at the NRPCA office, Box 1211, Waterville, ME 04901, telephone (207) 873-7784.

Have You Been Sued Lately?

The Risk Management Seminars have been a tremendous success. Some 1700 Georgia physicians have attended the 19 Risk Management Seminars sponsored by the Medical Association of Georgia. After completing the seminar, you can reduce your liability insurance premiums by 10% for the first renewal, 8% for the second, and 6% for the third. This premium discount is honored by both MAG Mutual and St. Paul.

A seminar is being planned for Savannah in early 1983. If you have not attended a Risk Management Seminar but would like to, send your name, address, phone number and the desired location (city) of the seminar to: Wayne W. Oliver, Medical Association of Georgia, 938 Peachtree Street, NE, Atlanta, Georgia, 30309.

Report by the Georgia Student Delegation to the Annual AMA/MSS Convention of 1982

Thanks to sponsorship by the Medical Association of Georgia, two students from Georgia medical schools were able to attend the Medical Student Section (MSS) meeting of the annual American Medical Association convention in June of this year. They were Leon Dent, Class of '85, from the College of Medicine at Morehouse University, and Karolyn Kramer, Class of '84, from the Medical College of Georgia. The following is a summary of the issues as well as their impressions of the meeting.

It's always very stimulating to interact with medical students from other schools; this year was no exception, as 94 of the nation's medical and osteopathic schools were represented in the MSS Assembly, with more than 160 students in attendance. The meeting was tightly organized: two Reference Committees heard testimony on twelve reports and twenty-two resolutions Friday, June 11; on Saturday, June 12, the Committees presented their recommendations to the Assembly for voting action; and on Sunday, workshops on various topics of student interest were held. There was one last meeting late Sunday afternoon to organize student testimony on MSS resolutions to be presented to the AMA Reference Committees on Monday morning.

Nine resolutions were submitted by the MSS to the AMA House of Delegates for consideration. Probably the most controversial resolution in the Student Section involved student recruitment by the Ohio State Medical Association (OSMA). In order to elicit membership and educate students about the benefits of organized medicine, the OSMA paid the AMA/MSS dues of $15 for all medical students (3,000) unless they sent back a pre-paid postcard stating they did *not* want this service. Coincidentally, by this same membership drive, they gained three new seats in the AMA House, where delegate seats are based on the number of members in the state, and students count as members. When asked if any of the new seats so gained were given to students, the OSMA staff person said no, they couldn't take time off from their studies to campaign for election to a seat. After much heated debate, both pro and con, the MSS Assembly took a stand against student membership recruitment methods that require direct action for refusing the offer and expressed opposition to full subsidization of AMA student dues by constituent societies. The MSS Governing Council felt great concern that its ranks had been swelled by 12% (from 21,000 to 24,000) and that it was not representing those students who had been "bought." The Assembly agreed that innovative recruitment methods were not to be discouraged but that a more active participation by the student reflected a genuine desire to be a member. Therefore, the MSS asked the AMA to study the medical student recruitment activities of state medical societies, and report on the impact of these activities on the composition of the House to the 1982 Interim meeting.

Action: The resolution was referred to the Board of Trustees for further study.

The second major topic of concern to students was the Council of Medical Education's report, "Future Directions." This fifty-page, two-year study was comprehensive in its assessment of undergraduate, graduate, and continuing medical education. The debate in the MSS centered primarily on the proposal for a reinstatement of a broad year of general training for all graduates. The student Assembly voted to support the report with some amending, and to express opposition to any increase in the length of postgraduate medical education at the AMA Reference Committee meeting.

Action: The AMA also amended the report in several different areas, suggested an "ideal" of a broad general training, and adopted it.

Other resolutions presented to the AMA Reference Committees by the MSS:

— That the AMA endorse the efforts of community health clinics in which students are involved and to encourage the development of such clinics.

Action: Not adopted.

— That the AMA Board of Trustees study the problem of improper handling of hazardous pharmaceuticals in developing countries by United States' companies.

Action: Amended and referred to the Board of Trustees.

— That the AMA study the medical effectiveness of the relocation and shelter plans proposed by the Federal Emergency Management Agency, and report back to the House at the 1982 Interim meeting.

Action: Adopted.

— That the AMA urge increased efforts to collect overdue debts to student loan programs in a way that will not interfere with the availability of future loans to medical students, and to encourage medical school financial aid officers to counsel individual students in regard to the status of their loans.

Action: Adopted.

— That the AMA research the problems of increased indebtedness on career choices, and to assess the importance of this in determining the specialty and location choices of new physicians.

Action: Adopted.

— That the AMA support legislation for the prevention of deaths and injuries in car accidents by the usage of seat belts.

Action: Adopted.

— That the AMA study the safety, efficacy and cost effectiveness of the pneumococcal, influenza, and hepatitis-B vaccines.

Action: Adopted.

Mr. Dent attended the AMA Reference Committee hearings Monday, June 14; as it was his first national convention, he was particularly interested in seeing the MSS defend its resolutions presented to the House. His conclusion was that MSS testimony on the various resolutions and reports, all conducted simultaneously in the eight committees, was well-coordinated and effective. Ms. Kramer was called back to her ward duties as a junior medical student, and was unable to attend the Monday morning hearings.

There was a growing ground swell of opinion within the student ranks that the southern schools must increase their representation at MSS meetings to broaden the scope of resolutions sent to the AMA, in order to prevent the

(Continued on following page)

Association from receiving regionally-biased student opinion. The discussion thus far has centered around formation of a Southern Caucus, as a way to increase the strength of southern schools and to insure parity within the MSS for all regions. Your Georgia student delegates are working on this; we hope to have a breakfast meeting of all interested southern schools at the Interim meeting in December in Miami.

We would like to conclude this report of the 1982 Annual AMA/MSS meeting by expressing our appreciation to the MAG for the opportunity to attend and represent medical schools in our state.

Karolyn Kramer, '84, MCG
Leon Dent, '85, Morehouse

Drinking During Pregnancy Discouraged

Physicians should advise pregnant women that the safest course to protect the fetus from damage due to alcohol is to abstain from drinking, witnesses for the American Medical Association told Congress.

LeClair Bissell, M.D., a member of the AMA's Panel on Alcoholism, told the Senate Labor and Human Resources Subcommittee on Alcohol and Drug Abuse that "research clearly indicates that excessive use of alcohol during pregnancy can negatively affect the fetus." Dr. Bissell said some research "suggests that even moderate use of alcohol" may be damaging.

In advising their patients, "physicians should be explicit in reinforcing the concept that, even with several aspects of the issue still in doubt, in view of the possibility of serious damage to the brain and body of the unborn the safest course is abstinence." Dr. Bissell noted that this policy was adopted by the AMA House of Delegates last June in connection with the adoption of a major report entitled "Fetal Effects of Maternal Alcohol Use."

Jokichi Takamine, M.D., also a member of AMA's Panel on Alcoholism, said the AMA strongly supports public education efforts to increase public awareness on fetal effects of alcohol. A booklet on the subject is being prepared by the AMA. Dr. Takamine noted that the AMA supports a warning label on alcohol containers stating that alcohol "may be injurious to your health and, if consumed during pregnancy, to the health of unborn children."

Pacemaker Costs Criticized and Defended

Tighter federal reimbursement standards for pacemaker costs appeared likely in the wake of three separate reports charging abuses and overpricing. All of the reports alleged or cited allegations that pacemakers have been over prescribed due to high-pressure sales tactics and kickbacks to physicians from salesmen.

The latest report came from the staff of the Senate Aging Committee which concluded that "the necessity or appropriateness" of as much as half the $2 billion cost of pacemaker procedures to Medicare "can be questioned."

Earlier reports along much the same lines have been issued by the Health Research Group associated with Ralph Nader, and the Health and Human Services Department's Inspector General Office. The FBI is conducting an investigation.

At a hearing by the Senate Aging Committee, Whitney McFarlin, Vice President of Pacing Systems Group Medtronic, Inc., a pacemaker manufacturer, defended the pricing system, declaring that "from the earliest years of the industry to the present, pacing has been a cost-effective treatment." He said a recent study of cardiac pacing costs "show that the total cost of treating the pacemaker patient dropped 43 percent from 1965 to 1980."

McFarlin said his company "deplores" questionable sales practices cited in the staff report and welcomes efforts to "bring about reforms in our industry."

The Senate staff study said "the key to the abuses . . . lies in the symbiotic relationship of the physicians and the pacemaker salesman" with "creative marketing devices" to encourage physicians to prescribe pacemakers.

Among such inducements mentioned in the report were stock options for consulting arrangements, payments of up to $25,000 for "clinical evaluations" of new products, cash payments for each pacemaker implanted, vacations, junkets, and gifts.

Russell Chambers, President of Intermedics, Inc., another pacemaker manufacturer, told the Committee that the staff report was "replete with errors, misrepresentation, and innuendoes." He said the cited costs of pacemakers to the makers does not include expenses relating to research and development, selling costs, interest on bank borrowings and "a variety of other general and administrative costs."

Brendan Phibbs, M.D., Chief of Medicine at Kino Hospital, Tucson, AZ, said studies have shown that from 10 to 80 percent of implants in Arizona may have been unnecessary. However, Seymour Furman, M.D., of Montefiore Hospital, New York City, questioned whether there was a significant percentage of unnecessary implant procedures.

Chambers said today's pacemakers last four times as long as earlier ones, meaning that the cost "has actually declined with advances in technology."

(Editor's note: We are familiar with the adage that the past can teach us much about the present and future if we will but take the time to look through history's pages. Such lessons can be entertaining as well as enlightening. Reprinted below are excerpts from a paper presented by Dr. Charles Rieser, of Atlanta, to the General Session of the Medical Association of Georgia on May 13, 1952, and published in the Journal *that same year. Dr. Rieser was a member of the Advisory Board of the National Doctors Committee. Of special interest is his description of the Hoover Commission's recommendation to create a Department of Health "because the [federal] government has no coordinated plan of operation for providing . . . [medical] . . . facilities, [and] there has been waste, inefficiency, and confusion in the duplicating operation of five large and over 30 smaller federal medical systems." One might ask how much things have really changed in 30 years. Take a look back by reading Dr. Rieser's comments and enjoy the 20/20 vision that hindsight so clearly renders.)*

The Doctor of Tomorrow and Federal Medical Services

The Hoover Commission was unanimously created by Congress in 1948. The Commission consisted of 12 men, six Democrats and six Republicans, selected by President Truman. In addition, the presiding officers of the Senate and [of] the House of Representatives were members. At President Truman's suggestion, former President Herbert Hoover was named chairman of the commission. The members served for 14 months or more without pay. In order to accomplish the task of attempting to streamline the various government agencies, the commissioners were aided by 24 research committees which were called "task forces." Among those committees there was a medical task force of 17 men. Eleven of the 17 men were physicians, and the remaining six were experts in hospital administration. Seven of the 17 men were veterans of World War II. Following a thorough study, the Hoover Commission made its historic report to Congress in 1949. The commission stated that, "The government is moving into uncalculated obligations without an understanding of their ultimate costs." The Commission found the Federal government today is obligated for the medical care of 24 million citizens of whom 19 million are veterans. Furthermore, "integration and coordination of our enormous and expanding Federal, State, and Local medical services could save 150 million dollars in administrative and hospital construction costs." By the cancellation by Congress of the bill to restore 16,000 VA hospital beds, this 150 million dollar saving has already been effected. The saving does not include the estimated average operating cost of $12 per day per patient. Under the Hill-Burton Act, the government is pledged for assistance to voluntary and civilian hospitals in building or expansion operations.

The commission also found that because the government has no coordinated plan of operation for providing the above mentioned facilities, there has been waste, inefficiency and confusion in the duplicating operation of five large and over 30 smaller federal medical systems. The Army, Navy, Air Force, Veterans Administration, and Public Health Service are operating completely independently of each other. These agencies are competing for buildings, equipment and personnel. Facilities of one agency are often crowded, while those of a different branch quite possibly nearby are half empty and their personnel correspondingly idle. Because of their findings, the commission recommended that Federal Medical Facilities be unified. This would mean the creation of a "Department of Health," by which means it would be possible to effect economy in manpower, space, and equipment. There would also be assurance of the wise use of professional talent and the proper economic use of existing facilities. The economic importance of eliminating waste and reduplication is glaring, when it is realized that Federal Medical Activities cost above 2 billion dollars per year. The recommendations of the commission are now summarized before Congress embodied in two bills. These are Senate Bills S 1140 and House of Representatives Bill HE [sic] 3305. A few examples of waste and excessive expense may be outlined as follows:

In the Veterans Administration during the past year there were approximately 600,000 cases [sic] admitted to the hospitals. Of these only 13 per cent were considered service connected injuries or illnesses.

Because of 88 different manuals, 665 varieties of technical bulletins, and the expansion of 9 pages of public law into 994 pages of "explanation," the commission recommended reorganization of the Veterans Administration.

Another disservice results from laxity in the enforcement of the law, by which many veterans obtain admission to government hospitals for free care simply by signing a so called "Paupers Oath," that they are unable to pay. According to Senator Paul H. Douglas of Ill., an outstanding exponent of economy in government, this practice cost several hundred million dollars annually. Due to the lack of an overall large plan by which the medical needs of the population might be appraised, there is ineffective use of the nation's medical manpower and facilities. Some institutions are over-staffed with insufficient numbers of patients for the various reasons.

Under the Hill-Burton Act the government approved the construction of 1,596 projects at a total cost of about 433 million dollars. Because of poor planning, many of these projects have been started more or less needlessly in the neighborhood of existing facilities which were not fully occupied. In some sections, large veterans administration hospitals are being built while nearby military hospitals are being shut down. A further demonstration of waste becomes evident when one compares the average cost of construction per hospital bed. In voluntary hospitals, the cost is about $16,000, while in federal hospitals, the cost is $32,000.

Because of the findings of the Hoover Commission, the National Doctors Committee for Improved Federal Medical Services was created. This committee is an affiliate of the Citizens Committee for the Hoover Report. The Committee was established as a means of informing 200,000 odd physicians in our country of all the pertinent facts in the field of National Health as ascertained by the survey made by the Hoover Commission. The Medical Advisory Board of this Doctors Committee is composed of specialists representing all 20 branches of the medical profession. All members of this board as well as the chairman of each of the 48 state committees, have given their services gratis and in the spirit of public service. This

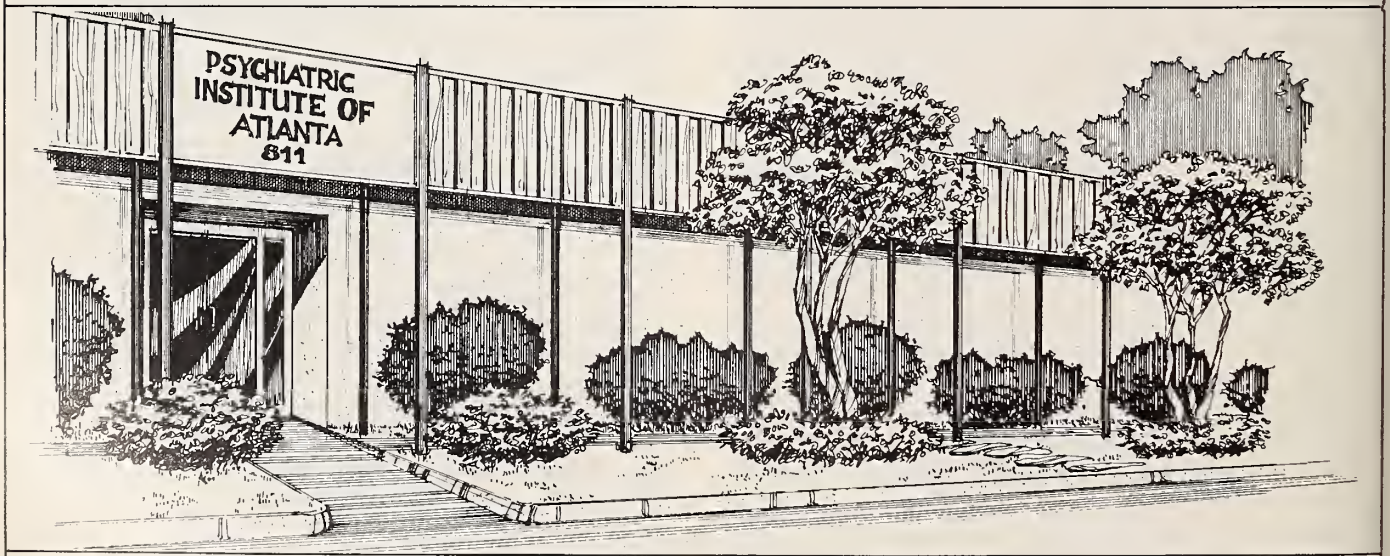
committee has two primary objectives: first, the coordination and organization of Federal Medical Services so as to provide maximum and efficient service to the beneficiaries of Federal Medical Care at a cost within the capacity of the taxpayers to pay; and second, the conservation and maximum utilization of the nation's supply of trained doctors, nurses, and technicians. By no stretch of the imagination is this group urging socialized medicine. On the contrary each and every one of the 3,000 plus members totally oppose the very idea of socialized medicine in any form. The motto of this temporary organization is "not more government in medicine but better medicine in government." Because Senate Bill S 1140 and House of Representatives Bill HR [sic] 3305, which represent the recommendations of the Hoover Commission to create in the government a department of health which has cabinet rank, have laid on the desk of Congress for two years, the National Doctors Committee has had for its main purpose the urging of Congress to give this proposed legislation fair consideration and prompt hearing.

These bills suggest the general benefits which would be an outgrowth of the reunification and coordination of the entire federal medical system. There would be tremendous advantages to be obtained in the field of research and preventive medicine, more effective and efficient service would be rendered and available to veterans, and adequate care for the general public would become available in the case of atomic war. The creation of a department of health would be constructive to the beneficiaries of Federal Medical Services, to the doctors, nurses, and the technicians who would be a part of the department, to the taxpayers of the nation, and to the entire medical profession.

The "climate" in Washington at the present time is right for achieving some reforms in the Federal Medical System. Members of Congress are aware that something should be done to strengthen the present set up and halt the "back door" approach to socialized medicine. Today we are stymied to a large extent because no major medical organization or recognized medical group except the voluntary and temporary National Doctors Committee has come forward to support the reforms.

If the doctors do not cooperate to correct this vital situation, if the needed reforms are not carried out, the physicians themselves must be prepared to accept part of the blame. It will be only a matter of time before the medical profession in this country will find itself in exactly the same predicament for which the British medical profession must assume the major responsibility. You have all recently seen the aggressive attitude and socialistic trend of the thinking of the government in Washington in the seizure of the steel industry. This is an obvious warning. There is no road back. Let us in America keep our ideal of private initiative and efficiency born of private enterprise. By unification of our Federal Medical System, so as to have maximal utilization of medical manpower, facilities, and equipment, we would be protecting our way of life in the field of medical practice. By the creation of a "Department of Health," manned by men learned in the medical arts, a further gap would be sealed from the grasping hand of the politicians, whose ambition it is to take over the practice of medicine.

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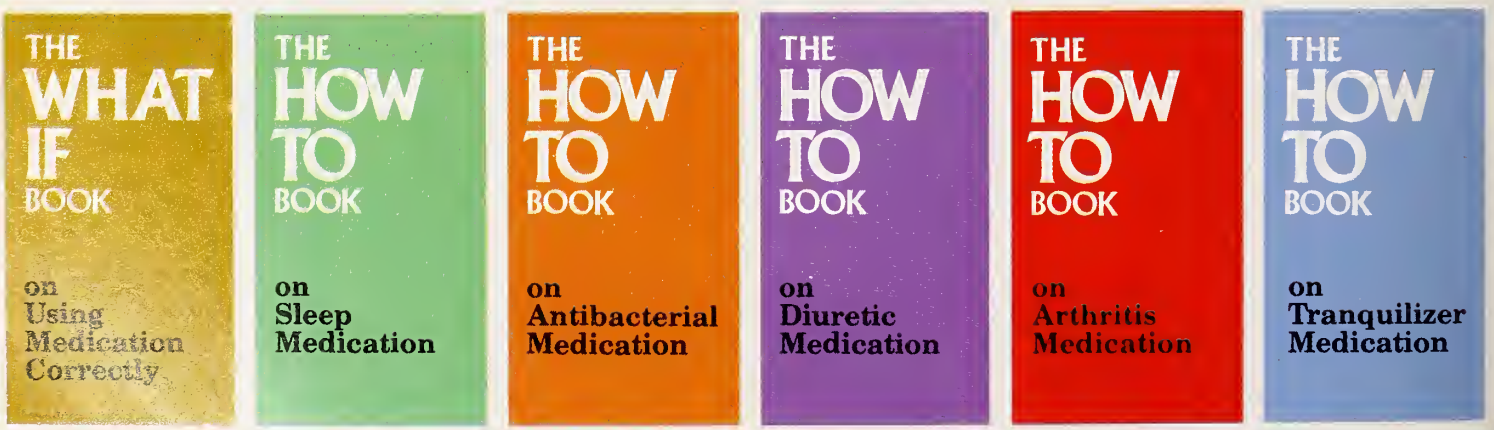
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3-4 — *Atlanta:* **Clinical Management of Coronary Disease and Dual-Mode Exercise Testing.** Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

3-5 — *Atlanta:* **International Symposium on Medical and Scientific Writing.** Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

4-5 — *Atlanta:* **Regional Anesthesia: Surgery, Obstetrics, and Pain.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

9-10 — *Atlanta:* **MKSAP VI Review Course.** Contact Registrar, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. PH:800/523-1546.

18 — *Atlanta:* **Depression and Anxiety: Treatment and Advances.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

JANUARY — 1983

13-14 — *Atlanta:* **Imaging 1983: Computed Tomography, NMR, Ultrasound.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-22 — *Atlanta:* **Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

30-Feb. 3 — *Cancun, Mexico:* **5th Annual Scottish Rite Pediatric Postgraduate Course — Pediatrics in Review.** Category 1 credit. Contact Judson Hawk, Jr., MD, Scottish Rite Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/256-5252.

FEBRUARY — 1983

5-13 — *Limone, Italy:* **7th Annual Conference on Pain — Chronic Pain: An International Epidemic.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-25 — *Park City, Utah:* **Urology in the Wasatch Mts.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-26 — *Augusta:* **Eighteenth Annual Family Practice Symposium.** Category 1 and AAFP prescribed credits. Contact Ms. Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-March 5 — *Breckenridge, Colo:* **8th Annual Snow Job in GYN/OB.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. School of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

MARCH — 1983

1-4 — *Durango, CO:* **Sixth Annual Symposium on Emergency Medicine.** Category 1 and AAFP prescribed credits. Contact Dir., Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

3-5 — *Augusta:* **Electrocardiography and Arrhythmias.** Category 1 and AAFP prescribed credits. Contact Ms. Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

24-25 — *Atlanta:* **Practical Use of Antibiotics: Update for the 1980s.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

26-27 — *Augusta:* **Spring Meeting, Georgia Chapter, American College of Surgeons.** Category 1 credit. Contact LaMar McGinnis, M.D., 365 Winn Way, Ste. 201, Decatur 30030. PH:404/292-2700.

27-29 — *Atlanta:* **MKSAP VI Part II — ACP.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

28-30 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

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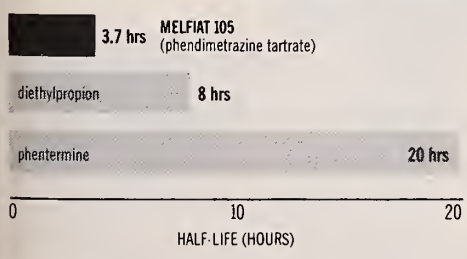


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References: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine,* unclassified document ADAMHA, HHS. Office of Medical and Professional Affairs, NIDA, 1980.
2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

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WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

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USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.
Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
Allergic: Urticaria.
Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

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CAUTION: Federal law prohibits dispensing without prescription.

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Letter to the Editor . . .

Yet More on HMOs

Dear Dr. Felder:

I have read your recent editorial in the MAG *Journal* concerning HMOs with great interest, and I see that you and I share many opinions concerning HMOs and the impact they have on the physician-patient relationship and the practice of medicine.

As you know, the Medical Practice Committee of the DeKalb Medical Society continues to meet and study this subject, and we are continuing to take action to see that the viewpoints you have expressed have some chance of becoming known to both our patients and to our fellow physicians. Of course, none of us has either the time or the resources to match the promotional efforts of either the Federal government (Did you see the direct mailing listing of HMO option to all Medicare beneficiaries in the Atlanta area?) or that of large insurance companies.

Currently, the Medical Practice Committee of the MAG is also developing a brochure comparing HMO medicine to that of fee-for-service private practice as obtained through traditional insurance. Hopefully, this will succeed in expressing some of the concerns that the overwhelming majority of MAG physicians have about HMOs and thus be something more than the usual mealy-mouthed type of statement that says nothing that is typical of the efforts of the AMA.

I do think that HMOs will always fill a place for a certain number of patients and physicians in any community and that both will seek their own level and type of health care delivery system. My main concern is that both patients and physicians be totally informed of the pros and cons before making such an important decision. The presence and promotion of HMOs in the Atlanta area, however, should never be regarded as a threat to those of us who prefer not to practice medicine along these guidelines, because HMOs can never compete on an even basis with hardworking, private practitioners who show their concern by providing personalized service to their patients.

Sincerely,
Nicholas M. Bath, M.D.
Atlanta urologist

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Cardiac Pacemaker Therapy at Grady Memorial Hospital, 1964-1978
(With Patient Follow Up Through 1980)

JEFFREY R. HOOPES, M.D., PANANGIOTIS N. SYMBAS, M.D., and
NANETTE K. WENGER, M.D., *Atlanta**

Introduction

THIS STUDY retrospectively reviews permanent pacemakers implanted in patients at Grady Memorial Hospital from 1964 to 1978; it includes a follow up of patients through June of 1980. Data collected include the diagnosis and/or symptoms requiring pacemaker therapy, the age and sex of the patient, associated diseases, the type of pacemaker used, complications of pacemaker therapy, and patient survival. This information should help in the selection of prospective pacemaker pulse generator and lead systems. Recommendations for the follow-up care of pacemaker patients are also specified.

Material and Methods

A total of 175 patients had permanent pacemakers implanted in the 14 years between 1964 and 1978 (Table 1). Sixty-two patients (35%) with permanent pacemakers died at an average of 2.7 years (range < 1-159 months, median 17 months) after pacemaker implantation. Forty-seven patients (27%) were lost to follow up because of transfer to nursing homes in other communities shortly after discharge from the hospital. Sixty-six patients (38%) are currently followed in the Cardiac Clinics; their average duration of follow up is 5 years (range 12-156 months, median 46 months) after pacemaker insertion.

The study population included 81 males (46.3%) and 94 females (53.7%). This slight female preponderance differs from the slight male preponderance at all ages in three other series of patients with pacemakers: 848/1560 (54.4%),[1] 77/130 (59.2%),[2] and 28/48 (58.3%).[3]

The age range at pacemaker implantation was 1-102 years, with a mean age of 67.5 years and a median age of 70 years. If the seven patients who required pacemaker insertion at the time of cardiac surgery are excluded, the age range is 30-102 years, with a mean of 71.3 years and a median of 71 years. Even these latter figures represent a somewhat younger population than in most other series of patients with pacemakers.[1] However, our patients who required pacemaker therapy for complete heart block (age range 30-89 years, mean age 70.5 years, median age 71 years) were of comparable age to those reported in other series (range 29-85 years, mean age 65 years) (Table 2).

The diagnoses which mandated pacemaker insertion included: high-degree antrioventricular block [complete heart block (86), Mobitz type II (5), and bi/trifascicular block (4)]; sick sinus syndrome [sinus bradycardia (8), sinus arrest (11), and bradycardia-tachycardia syndrome (10)]; conduction defects associated with acute myocardial infarction (7); complete heart block after cardiac surgery (7); panconduction defects [atrial fibrillation with slow ventricular response (6), bilateral bundle branch block (1)]; hypersensitive carotid sinus syndrome (1); combination of above plus miscellaneous diagnoses (17).

Pacemakers were implanted because of syncope or near syncope in 41% of our patients. Other major presenting symptoms are summarized in Table 3.

* Drs. Hoopes and Wenger are from the Division of Cardiology, Department of Medicine, and Dr. Symbas is from the Department of Surgery (Thoracic and Cardiovascular), Emory University School of Medicine, and Grady Memorial Hospital, Atlanta. Send reprint requests to Dr. Wenger, Professor of Medicine (Cardiology), 69 Butler St., SE, Atlanta, GA 30303.

TABLE 1 — Patient Status by Year of Initial Pacemaker Implantation, Grady Memorial Hospital, Atlanta, Ga., 1964-1978

Year of First Implantation	Total Number of Patients	Number Currently Followed	Number Dead	Mean Longevity After Pacemaker Implantation of Patients Who Died	Number Lost to Follow up
1964	2		1	4.0	1
1965	5		4	2.5	1
1966	6	1	5	4.0	
1967	5		3	4.3	2
1968	16	1	10	1.8	5
1969	13		6	3.2	7
1970	14	5	3	3.3	6
1971	15	2	5	4.4	8
1972	19	5	11	2.0	3
1973	12	3	8	1.2	1
1974	12	6	1	2.0	5
1975	11	6	2	1.0	3
1976	13	13			
1977	16	12	2	2.0	2
1978	16	12	1	1.0	3
Total	175	66	62	2.7	47

TABLE 2 — Patient Age at Pacemaker Implantation and Clinical Characteristics, Grady Memorial Hospital, Atlanta, Ga., 1964-78

	Grady Memorial Hospital								All Pacemakers 1965-1968 MGH[2]	
		Number Implanted Not Related to Cardiac Surgery		Complete Heart Block		Complete Heart Block[3]		All Paced Patients[1]		
Age at Pacemaker Implantation	Total Number Implanted	Number of Patients	Percent	Number of Patients	Percent	Number of Patients	Percent	Percent	Number of Patients	Percent
Under 50	16	9	5.7	6	6.7	6	12.5	4	4	3.3
51-60	21	21	13.4	7	7.8	14	29.1	7	4	3.3
61-70	49	49	31.2	31	34.8	14	29.1	21	24	19.8
71-80	46	46	29.3	24	27.0	11	22.9	40	53	44.2
81-90	27	27	17.1	18	20.2	3	6.3	25	30	25.2
Over 90	5	5	3.2	3	3.4	0	0.0	3	5	4.2
	164	157	99.9	89	99.9	48	99.9	100.0	120	100.0
Age Range	1-102	30-102		30-89		29-85				
Mean Age	67.5	71.3		70.5		65				
Median Age	70.0	71.0		71		NA				

NA = not available.
* Percent with complete heart block not available.

TABLE 3 — Major Presenting Symptom for Pacemaker Implantation, Grady Memorial Hospital, Atlanta, Ga., 1964-1978

Major Presenting Symptom	Number of Patients	Percent
Syncope	72	41.1
Near Syncope	35	20.0
Congestive Heart Failure	15	8.5
None	9	5.1
Stroke	2	1.1
Cardiac Arrest*	2	1.1
Palpitations	1	0.6
Chest Pain*	1	0.6
Unknown	38	21.7
TOTAL	175	99.8

* Slow ventricular response felt to be contributory to these symptoms.

Approximately half of all patients had documented symptomatic relief after pacemaker insertion, while 7% continued to have symptoms after pacemaker implantation. The remainder were not followed for sufficient time to judge symptomatic relief or had symptoms which could not be accurately assessed. Of the patients followed for sufficient time, the best documented symptomatic relief was for syncope (93%), whereas about 80% of patients with congestive heart failure and near syncope had symptomatic improvement.

Frequent associated diseases included the following: atherosclerotic coronary heart disease (27%), systemic arterial hypertension (34%), stroke or transient ischemic attacks (14%), and diabetes mellitus (adult onset 10%, insulin-dependent 2%).

TABLE 4 — Patients With Implanted Pacemakers, Age at Death, Grady Memorial Hospital, Atlanta, Ga., 1964-1980

Age at Death	*Number of Patients*
Under 50	4
51-60	5
61-70	10
71-80	21
81-90	13
91-100	5
Over 100	1
Average: 70.7	

TABLE 5 — Patients With Implanted Pacemakers, Cause of Death, Grady Memorial Hospital, Atlanta, Ga., 1964-1980

Cause of Death		*Number of Patients*
Cerebral		14
Heart disease		14
terminal congestive heart failure	5	
arrhythmia	6	
acute infarction	3	
Post-operative pacemaker implantation		3
Renal failure		3
Peripheral vascular disease		3
Other		9
Pacemaker-related		1
Unobserved death without recent change in clinical status		15
Total		62

Data about death following pacemaker insertion are known for 62 patients. Their ages and causes of death are presented in Tables 4 and 5. Very few deaths were directly related to pacemaker implantation or to pacemaker failure. Three deaths occurred at or soon after thoracotomy for direct epicardial lead implantation in patients considered to be at high operative risk. One death is known to be due to pacemaker failure; this patient required a pacemaker for sinus bradycardia after aortic valve replacement; failure to pace was documented on ambulatory ECG recording shortly before death. Fourteen deaths were due to cardiac disease. Six patients died of arrhythmias, five of endstage heart failure (underlying disease unknown), and three of acute myocardial infarction with pump failure. In three of the patients with arrhythmias, pacemaker implantation was for arrhythmia control. In one instance, the arrhythmia followed an acute myocardial infarction; and in two, arrhythmias were terminal events in patients with severe multisystem disease. Fourteen deaths were due to neurologic disease (dementia, stroke, meningitis), three to peripheral vascular disease, and nine to miscellaneous causes (septicemia, pneumonia, fractured femur, carcinoma, motor vehicle accident, ulcerative colitis). The precise cause of death is unknown for 15 patients whose age at death averaged 80 years.

Patient Survival After Pacemaker Implantation

Forty-seven of the 175 patients (27%) were not seen for follow up after pacemaker implantation due to transfer to nursing homes soon after discharge from the hospital. Sixty-two of the 128 remaining patients (48.4%) died during the period of surveillance; the mean age at death was 70.2 years (range < 1-103 years, median age 75 years). The duration of pacemaker therapy prior to death in these 62 patients varied from 1 to 159 months, with a mean pacing duration of 30.9 months (median 17 months); 24 (39%) of the 62 deaths occurred within 6 months of pacemaker implantation.

The mean age of the men at pacemaker implantation was 67.9 years (range 31-102 years, median age 70 years); their mean pacing duration was 35.6 months (range <1-159 months, median 20 months), with a mean age at death of 70.7 years. For women, these data were a mean age of 69.4 years at pacemaker implantation (range <1-91 years, median 72 years); mean pacing duration of 29.3 months (range <1-146 months, median 16 months); and mean age at death of 71.8 years (range <1-95 years, median 73 years). It should be kept in mind that 25% of our patients were lost to follow up immediately after the hospitalization for pacemaker implantation.

Among the patients in our series, survival after pacemaker implantation appears age dependent after age 80; but the statistical significance of this observation cannot be assessed due to the small numbers of patients. Survival of our patients with pacemakers aged 61 years and older was less than that for both the general age-matched U.S. population and for comparably aged patients reported in other series of pacemaker patients.[1]

Patients with atherosclerotic coronary heart disease had a higher mortality rate (44.7% vs 31.6%) and a shorter mean life expectancy after pacemaker insertion (29 months vs 48 months) than patients with systemic arterial hypertension (Table 6). The small number of patients with neither systemic arterial hypertension nor atherosclerotic coronary heart disease precludes comparison with patients with pacemakers without these associated diseases. The 1969 report of Hawthorne, et al[2] noted a higher percentage of pacemaker patients with diabetes mellitus (35% vs 12%) but a smaller percentage with atherosclerotic coronary heart disease (23% vs 30%) and systemic arterial hypertension (14% vs 39%). Small numbers again preclude assessment of statistical significance. The prevalence of associated diseases in the general U.S. population of comparable age with which survival is compared is not known. The lesser survival of our population may reflect a

TABLE 6 — Paced Patient Longevity by Follow-Up Status and Presence of Other Diseases, Grady Memorial Hospital, Atlanta, Ga., 1964-1980

	Systemic Arterial Hypertension	*Atherosclerotic Coronary Heart Disease*	*Both*	*Total*
Number of patients	60	47	21	175
Mean age	67	71	68	63
Age range	31-87	46-93	46-86	<1-102
Standard deviation	9.4	9.7	8.6	23.6
Patients currently followed:	32	20	10	
Average follow up (months)	52	51	52	
Range of follow up (months)	12-113	11-119	16-113	
Lost to follow up*	9	6	1	
Died	19	21	10	
Average follow up (months till death)	48	29	49	
Range of follow up (months till death)	<1-105	<1-86	<1-86	

* Patients for whom data were available.

higher prevalence of associated diseases, but this cannot be ascertained.

Specific diseases associated with decreased survival after pacemaker implantation include cerebrovascular disease or stroke, atherosclerotic coronary heart disease, and insulin-dependent diabetes mellitus; among our patients, noninsulin-dependent diabetes mellitus and systemic arterial hypertension did not appear to be prognostic factors.

Survival was comparable for men and women in our series, as judged by a comparable ratio of males to females among patients with early mortality (within 6 months of pacemaker insertion), with late survival (greater than 5 years after pacemaker insertion), and the total population longevity at the time of pacemaker implantation. The male : female ratios respectively were 11 : 13, 25 : 34, and 81 : 94. Survival related to the diagnosis at implantation is shown in Figure 1. Although the small numbers preclude assessment of statistical significance, there appears to be better survival with sick sinus syndrome than with complete heart block.

Patients who survived less than 6 months after pacemaker implantation appeared to have had an increased incidence of cerebrovascular disease and atherosclerotic coronary heart disease, 4/24 and 10/24 respectively, compared with the population surviving more than 60 months after pacemaker implantation (3/59 and 15/59). These differences are not statistically significant, in part due to small sample size. Patients with both systemic arterial hypertension and atherosclerotic coronary heart disease had comparable longevity to those with atherosclerotic coronary heart disease alone. There was no difference in the incidence of adult onset diabetes mellitus or systemic arterial hypertension between short-term and long-term survivors. The two patients with insulin-dependent diabetes mellitus died within 6 months.

Pulse Generator Replacement and Complications with Different Lead Systems

The 175 patients in our series had a total 398 pacemaker-related procedures. After initial pacemaker implantation, 223 subsequent procedures were required either for elective pulse generator replacement or because of pulse generator or lead system failure. All procedures were performed by either a thoracic surgeon or by one of several thoracic surgery residents with direct supervision by an attending thoracic surgeon.

More than half of the 175 patients required a subsequent procedure; only 17 of the 65 patients currently followed in our Cardiac Clinics have had only an initial pacemaker implantation. All patients in this study had their initial pacemaker implantation between 1969 and 1978, a period characterized by limited pulse generator life, although the follow up reported is through June of 1980.

The pulse generator was changed in 199 of the 223 subsequent procedures. Of these, 61 (31%) were elective pulse generator changes near the end of generator life expectancy; the majority of these changes occurred during the early and mid 1970s, when the pulse generator life expectancy was about 2 years. Forty-six (23%) pulse generators were changed because of battery failure; these patients had either been lost to follow up and presented with recurrent symptoms of bradyarrhythmia or were being followed at close intervals because of anticipated battery depletion. The reasons for 38 (19%) of the pulse generator changes were not specified, and 29 (15%) required generator changing for unspecified pacer failure. The remaining pulse generator changes were done at the time of revision of an implant site (as for infection) or correction of lead system problems.

Fifty-one procedures were necessitated by problems with the lead system (Table 7). Three lead

TABLE 7 — Reasons for Pulse Generator Replacement and for Lead Replacement, and Lead System Complications by Lead Type, Grady Memorial Hospital, Atlanta, Ga., 1964-1980

		#2	#3	#4	#5	#6	#7	Total
Battery failure	PM	22	13	8	2	1		46
Failure for unknown reason	?	14	8	4	3			29
Local problem	L	5	3	1	2	1		12
Exteriorization	L		1	1				2
Reimplant	L				1			1
Elective pacemaker change	PM	35	12	10	2		2	61
Change for unknown reason	?	13	12	5	5	3		38
No change	L	11	4	4		1		20
Lead problem	L	2	2	1		1		6
Removal	N	1	1					2
Failure to sense	L	1						1
Competition	N	1						1
TOTAL		105	56	34	15	7	2	219

Reasons for Lead Replacement

	#2	#3	#4	#5	#6	#7	Other	Total
Failure to pace	5		3				8	8
Broken wire	3	3	3		1		8	10
Poor lead-pacemaker connection			1				1	1
Perforation or lead migration	6	1		1			8	8
Infection	4	1		1	1		7	7
Unknown reason for change	6	4	2	1	1		16	14
Not changed	58	30	18	6		1		113
Not known if changed	22	14	6	5	4	1		52
None replaced		1						1
High resistance	1	2	1	1			3	5
TOTAL	105	56	34	15	7	2	51	219

Lead System Complications by Lead Type

	Epicardial Sutured	Epicardial Sutureless	Transvenous	Total
Failure to pace	1		7	8
Broken wire	2	3	3	8
Poor lead-pacemaker connection		1		1
Infection	3		4	7
High resistance	1		2	3
Unknown reason for change	3	2	11	16
Perforation or migration	1	1	6	8
Changes due to leads	11	7	33	51
Not changed	15	26	71	112
Not known if changed	6	8	9	23
Total	32	41	113	186

systems were used during the years of this study: epicardial sutured leads, epicardial sutureless leads, and transvenous leads. A number of patients had more than one lead system used during their clinical course. Thoracotomy and general anesthesia were required to suture epicardial leads into the myocardium. This lead system was used between 1965 and 1975, and 80% of such leads were implanted between 1968 and 1972. Epicardial sutured leads were used initially in 18 patients and at some time in a total of 25 patients. The mean life of this lead system in our series (implant date to death, lead change, or lost to follow up) was 40 months, with a median lead life of 32 months. Eleven of the 32 procedures (34%) required by these patients were for lead system complications, including infection, broken wires, failure to pace, or high electrode resistance. This lead system was initially reliable, with only two lead system failures during the first 6 months. No patient in this group either died or was lost to follow up during the first 3 months of surveillance. The average longevity of the lead systems which failed was 58 months.

Epicardial sutureless leads,[6] implanted via a subxiphoid approach using local anesthesia, were the initial system used in 48 patients and at some time in a total of 74 patients. This lead system was used for initial implantation and lead replacement from 1969-1978, with 80% of the leads implanted after 1974. The mean length of pacing with this lead system was 34.4 months, with a median duration of 30 months. This patient group subsequently required 41 procedures, seven (17%) for lead system complications which were primarily wire breakage; the majority occurred after 4 years of pacer use.

Eighty-two patients had transvenous leads at their initial pacemaker implantation, and a total of 90

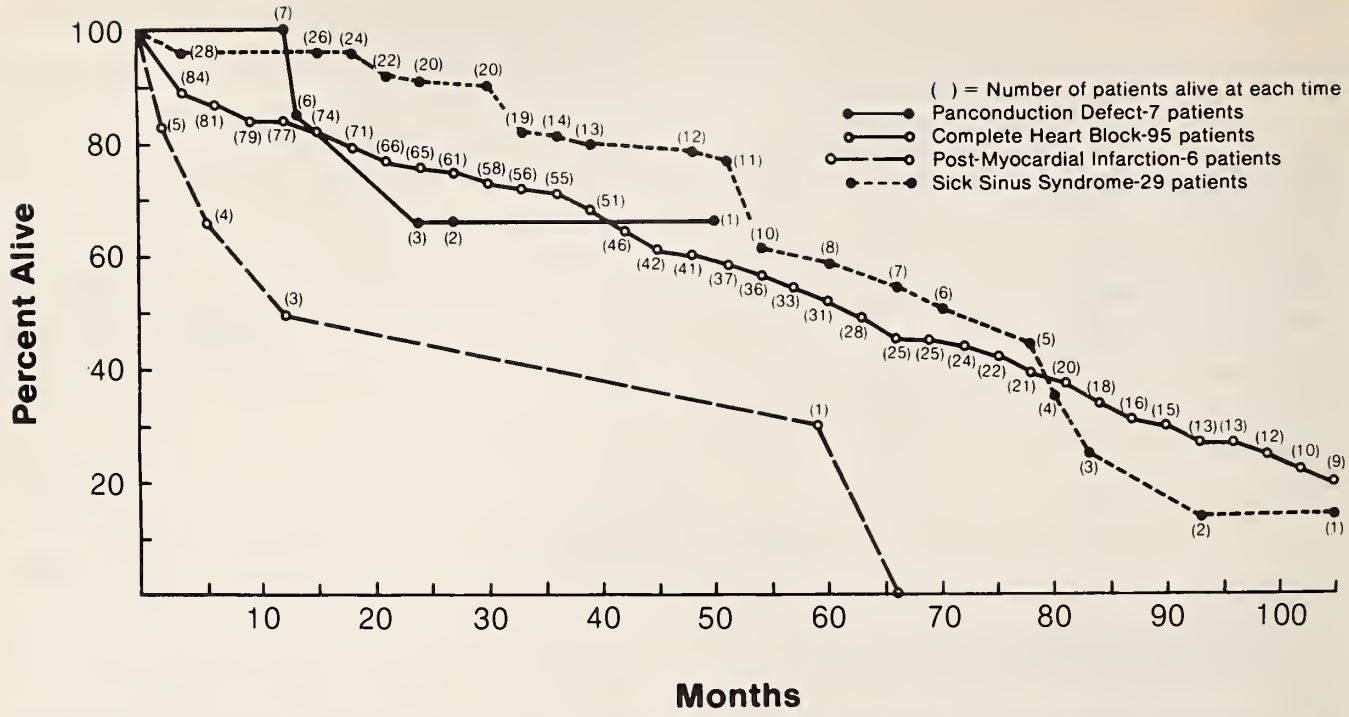


Figure 1 — Pacemaker Patients, Survival by Diagnosis, Grady Memorial Hospital, Atlanta, Ga., 1964-1980.

patients used this lead system at some time. The transvenous approach was used from 1964-1978, with over half of the leads placed between 1968 and 1972. The mean pacing duration with this lead system was 32.4 months, with a median duration of 25 months. These patients required 113 subsequent procedures, 33 (29%) for lead system complications. These problems usually occurred soon after implantation; 13 patients required lead changes during the first 6 months because of failure to pace and/or lead migration.

Epicardial sutureless pacemaker leads may be preferable for completely pacemaker-dependent patients who are considered good operative candidates.

The two epicardial lead systems have an increased stability of lead placement and do not exhibit the early problems seen with the transvenous leads; however, epicardial leads require thoracotomy. The lead complication rate of epicardial lead systems was about 3/5 that of the transvenous lead systems. The lead complication rate of the sutureless epicardial leads is one-half that of the sutured epicardial leads; this could be a function of improvement in lead technology and surgical technique, as the sutured leads were used almost exclusively prior to 1974 and the sutureless after 1974. The apparent longer lead life could also be due to the sutured epicardial leads being implanted in earlier years. The small sample size precludes more detailed analysis of early and late complications.

Discussion

Review of our patients with pacemakers, as compared with three other reported pacemaker populations, is characterized by a slightly higher female preponderance and a slightly younger age. When specific diagnostic groups are considered, the ages are comparable to the populations described in other reports.

Epicardial sutureless lead systems appear to have superior longevity, although the numbers in our groups were small, the procedures were not performed randomly during the same time period, and implantation of the transvenous leads was by several different thoracic surgery residents although supervised by a faculty attending surgeon. Despite these limitations, epicardial sutureless pacemaker leads may be preferable for completely pacemaker-dependent patients who are considered good operative candidates and for patients expected to have considerable longevity. This decision assumes the availability of a surgeon who is familiar with this lead system.

This information should help in the selection of prospective pacemaker pulse generator and lead systems.

Contemporary pacemakers are characterized by much longer generator life and a much wider range of features than those available during the years of our study. On the other hand, the patient population and the indications for pacemaker therapy remain comparable. Therefore, these data should influence

decisions about desirable features for pulse generators and lead systems.

Older patients (> 80 years) and patients with associated atherosclerotic coronary heart disease, insulin-dependent diabetes mellitus, and cerebrovascular disease appear to have a shorter life expectancy. In these population groups, it would appear reasonable to choose a pacemaker with a more modest battery life. Younger patients without these associated diseases would be candidates for pulse generators with the longest available life.

Acknowledgements

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Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

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DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

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Plesiomonas (Aeromonas) shigelloides Meningitis in a Neonate — A Case Report

A. GATEWOOD DUDLEY, M.D., WALLACE MAYS, M.D., and LARRY SALE, P.A., *Americus**

Abstract

***Plesiomonas (Aeromonas) shigelloides* is an infrequent cause of infection in humans and an even more infrequent cause of neonatal meningitis. The authors present a case report of neonatal meningitis secondary to *P. (A.) shigelloides* along with a discussion of the biochemical and morphologic characteristics of this organism.**

Introduction

Plesiomonas (Aeromonas) shigelloides is an infrequent cause of infection in humans and an even more infrequent cause of neonatal meningitis. Prior to this case, only two known cases have been reported.[1, 3] This organism has been isolated most often from patients with gastrointestinal symptoms and occasionally from patients with cellulitis in the extremities.[1-3, 5] The third case of neonatal meningitis due to *P. (A.) shigelloides* is described below.

Case Report

A 29-year-old white woman, gravida 2, para 0, abortus 1, was admitted to the hospital at an estimated 39 weeks' gestation with her membranes intact. Her pregnancy had been uncomplicated until admission when pre-eclampsia was diagnosed. She was hypertensive (BP170/110), hyperreflexic, and had 3+ albuminuria. The patient was given an intravenous infusion of magnesium sulfate and after stabilization, intravenous pitocin augmentation was begun. Because of a prolonged second stage of labor, low mid-forceps rotation and extraction was performed. A viable, 2807 gram male infant, Apgar 9/9, was delivered 10½ hours after the membranes had ruptured.

Uterine atony developed for which the patient received two units of blood. At no time did she have a fever or any other signs of infection. She did, however, have leukocytosis postpartum. Cultures of vaginal and blood specimens revealed no growth.

The infant was normal except for a small parietal hematoma without skin breakage. He was placed on routine nursery orders and was taken to visit the mother each day.

On the infant's second day after birth, he became noticeably jaundiced. No other symptoms or signs were present. Early on the fourth day, the first signs of acute illness were noted. The infant was irritable, with respirations of a grunting type. He passed several loose yellow stools and subsequently began vomiting. His temperature was 102.4°F. Cultures of throat and stool specimens were done as was a spinal tap. The spinal fluid was yellow and cloudy, and the leukocyte count was 2600 per cu mm consisting mostly of segmented granulocytes. The protein content was 443 mg/100ml., and sugar content was 6 mg/100ml. No organisms were seen on direct gram stained smear. The total serum bilirubin at this time was 7.7 mg%.

Acute meningitis was diagnosed, and treatment was begun. Intravenous fluids were started, with infusion of ampicillin 125 mg. (slow push) every 4

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hours. Gentamicin, 9 mg., was given intramuscularly every 12 hours. Phenobarbital was given as a sedative.

This organism has been isolated most often from patients with gastrointestinal symptoms and occasionally from patients with cellulitis in the extremities.

The infant's respirations became irregular, and his heart rate fluctuated between 50-100 beats per minute. Despite attempts at resuscitation, he died approximately 12 hours after onset of symptoms.

The autopsy demonstrated meningitis, cerebral edema, and softening of the cortex. In addition, there were multiple thrombi of small cerebral vessels and perivascular hemorrhage within which rod-shaped bacteria could be identified. The gram-negative rod, *P. (A.) shigelloides* was isolated from both blood and cerebrospinal fluid.

All possible water sources to the neonate were cultured and found to be negative.

Discussion

P. shigelloides, formerly in the genus *Aeromonas,* is still referred to as an aeromonad despite its biochemical and morphologic differences with the other aeromonas species.[2] It was named for its similar antigenicity to *Shigella sonnei* in 1947 by Ferguson and Henderson.[1] The aeromonads are gram-negative rods in the family *Vibrionaeceae,* and though they are similar and often confused with the *Enterobacteriaceae,* especially *E. coli,* careful differentiation is made using the indophenol oxidase test.[4] These organisms are oxidase positive, and their particular combination of sugar fermentations are found only with the aeromonads and vibrios.[3] Differentiation between the vibrios and the different aeromonads is by use of decarboxylase tests and by certain morphologic characteristics.[5] *P. shigelloides* is facultatively anaerobic, non hemolytic on sheep blood, and motile, possessing one to five long polar flagella.[3]

Aeromonads can survive a wide range of temperatures (0-45°C), which gives them a broad habitat. They are considered to be a part of the natural flora of most water systems and of soil. They are pathogenic for cold-blooded and warm-blooded vertebrates.[5]

The human gut is not a major reservoir, but these organisms have been isolated from feces, bile, sputum, and urine in the absence of disease. Well documented clinical disease is rarely reported, but aeromonads have been associated with septicemia, pneumonia, and gastroenteritis in man.

Treatment for aeromonad infections is with various antibiotics. *P. (A.) shigelloides* is sensitive to chloramphenicol, kanamycin, tetracycline, ampicillin, and gentamicin.[1-4]

The first reported case of neonatal *P. shigelloides* meningitis occurred in an infant whose mother had cellulitis of the leg for an undetermined period before delivery.[4] The second case of *P. shigelloides* meningitis in a neonate occurred with the likely source of infection being the mother's gastrointestinal tract. In this case as well, the likely source of infection was probably the birth canal or gastrointestinal tract.

In summary, the third known case of neonatal meningitis due to *P. shigelloides* is reported. It is possible that laboratory confusion with the *Enterobacteriaceae* has prevented some identifications of *P. shigelloides* infections in the neonate.

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Visual hallucinations, nightmares, and delusions are thought to be associated with the use of lipophilic beta blockers such as propranolol.

Central Nervous System Side Effects of Propranolol

S. K. TIKARE, M.D., and M. S. BANDISODE, M.D., *Augusta**

Introduction

BETA ADRENERGIC blocking agents have been in clinical use since 1964[1, 2] and have been proven to be effective in the management of several clinical conditions such as hypertension; angina pectoris; cardiac arrhythmias; thyrotoxicosis; essential, familial, and senile tremors; glaucoma; alcohol withdrawal; and the prophylaxis of migraine. The therapeutic indications for the use of beta adrenergic blocking agents seem to be growing.

The clinically important side effects of these agents, such as precipitation or worsening of congestive heart failure, impairment of atrioventricular conduction, worsening of bronchospasm in asthmatic patients, masking of the symptoms of hypoglycemia in insulin-treated diabetic subjects, and exacerbation of the symptoms of peripheral vascular disease, are widely known and easily recognized. The latter three adverse effects are more pronounced with the non-selective beta blockers, propranolol and nadolol, than with the cardio-selective beta blockers, metoprolol and atenolol.

The central nervous system (CNS) side effects of propranolol, vivid dreams, visual hallucinations, and insomnia, have been described in the past.[3] These CNS adverse effects of propranolol have been attributed to its high lipid solubility which causes high brain concentrations of the drug.[4] It has been reported that the severity and incidence of such side effects is less with water soluble beta blockers, e.g., nadolol and atenolol.[5]

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In the following case report, we describe an elderly patient who experienced severe CNS side effects with propranolol.

Case Report

T. M., a 69-year-old white man was admitted to the Stroke Rehabilitation Unit of the Veterans Administration Medical Center in Augusta on April 9, 1981, with a presenting complaint of increased weakness of the left upper and lower extremities.

The patient's history indicated that he had been diagnosed as hypertensive in December, 1980, and had received chlorthalidone and propranolol from his private practitioner. He experienced a stroke with left-sided hemiplegia on Jan. 29, 1981, and was initially hospitalized in Charleston, South Carolina, and later in Hampton, South Carolina. During his last hospitalization, chlorthalidone therapy was discontinued.

During this most recent hospitalization, propranolol, 40 mg. four times a day, was continued for the control of hypertension. He also received Digoxin, quinidine sulfate, bethanechol chloride, and ferrous sulfate. After 18 days, the patient experienced visual hallucinations (e.g., horse-drawn wagons running on the ceiling, ants crawling on the walls, camels without humps, etc.). He also experienced nightmares (a huge dog about the size of a mule jumping at him) and delusions (a feeling of a brace and a drill-bit broken in his rectum). These manifestations were thought to be the side effects of propranolol, and the drug was discontinued. He was then placed on nadolol, 80 mg. once a day orally, and hydrochlorothiazide, 25 mg. once a day.

The visual hallucinations, nightmares, and delusions gradually diminished during the next 3 days

and subsided completely thereafter. He remained symptom free for approximately 7 weeks on the above regimen.

The vivid dreams recurred, however, with much less intensity on June 15, 1981. The visual hallucinations and the delusions did not recur. Nadolol was discontinued because of this recurrence, and hydrochlorothiazide was increased to 50 mg. once a day orally. The vivid dreams subsided completely thereafter. Later, prazosin was added to the antihypertensive regimen.

The patient has remained free of the visual hallucinations, nightmares, and delusions for over 1 year until the time of this case report.

Discussion

The brain concentrations of three lipophilic beta blockers were reported to be higher than the concentration of a hydrophilic beta blocker by Cruickshank, et al.[4] The concentrations of lipophilic agent propranolol in the brain was 20 times greater and the concentrations of oxprenolol and metoprolol were 10 times greater than the brain concentration of the hydrophilic beta blocker atenolol. The marked difference in the brain concentrations of the lipophilic and the hydrophilic beta blockers reported in the previous study[4] may be clinically relevant to the high incidence of CNS side effects observed with propranolol.

Discontinuation of propranolol and its substitution by a less lipid soluble adrenergic beta blocker such as atenolol would be the most logical method of management of the patient experiencing adverse CNS effects.

The CNS side effects of the adrenergic beta blockers include dreams of a strange or vivid nature, often of a nightmarish quality, and visual hallucinations.[6] Greenblatt and Koch-Weser[7] examined the reports of the adverse reactions of oral propranolol in 797 patients and observed that the incidence of sleep disturbances including nightmares was 4.3%, and the incidence of visual hallucinations was 0.8%. Zacharias[8] observed that the CNS side effects were less commonly encountered with water soluble beta blockers atenolol and sotalol than with the lipid soluble beta blockers. The recognition of these distinctive adverse effects of propranolol is especially important in the elderly subjects, who often present with multiple medical problems and receive multiple medications concurrently.

Discontinuation of propranolol and its substitution by a less lipid soluble adrenergic beta blocker such as atenolol would be the most logical method of management of the patient experiencing the CNS adverse effects. At the time our patient experienced the CNS adverse effects with propranolol, atenolol was not approved for general use by the Food and Drug Administration. We therefore decided to substitute nadolol for propranolol. With this substitution, the CNS adverse effects subsided completely, and the patient remained asymptomatic for 7 weeks. It has been reported that nadolol is 2 to 4 times more potent than propranolol as a beta blocker.[9] The dose of nadolol used in our patient was, therefore, as potent as the dose of propranolol for its beta blocking effect. Although the recurrence of mild vivid dreams was encountered with nadolol after 7 weeks, the visual hallucinations and the delusions did not recur.

Our experience indicates that it may be possible to substitute a less lipophilic beta blocker, e.g., nadolol or atenolol, for propranolol when the CNS side effects are encountered with the latter agent. Whether atenolol produces less CNS side effects than nadolol is not known at this time. Further studies are needed.

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[Dr. Matthews] encourages every mother to strive to be "a somebody" in addition to being a mother.

Through the Motherhood Maze, With Dr. Sanford J. Matthews

EVELYN WARD GAY, ***Decatur****

He is called an "outspoken pediatrician." His ideas about the pressures of being a mother and an individual at the same time will be liked by some and disputed by others, but his words will be listened to by all who come within the range of his voice or who read his new book. He is forceful and dynamic, yet understanding and supportive of all mothers — and he loves children.

If all of this sounds contradictory, it isn't. It all comes together in the successful working philosophy of Dr. Sanford J. Matthews, who cares not only for the children who are his patients, but for their mothers as well.

His message is, quite simply: "In order to be a good mother, a woman must be happy and fulfilled as an individual."

Over a period of 27 years in practice in Atlanta, he has tested and proved his theories of bringing up happy, healthy youngsters, under the guidance of satisfied and balanced adults. Employing Carl Jung's doctrine, "Nothing has a stronger influence on children than the unlived life of the parents," Dr. Matthews regularly carries out counseling sessions with the parents of his patients.

The results of some of his consultations and his accompanying low-keyed advice have been put into a small, attractive volume coauthored by a young mother who is also a successful writer. *Through the Motherhood Maze* is subtitled *Survival Lessons for Loving Mothers* and is published by Doubleday and Company, Inc., of New York.

Throughout the pages of this concise and well written book are many sensible and homespun passages such as this: "Every child is a mother's responsibility. She must feed him, love him, hold him and bathe him, but fundamentally, her life can't be subordinate to his. If it is, then her own life will be miserable because he will be bugging her all the time. Furthermore, he will never learn life's big lessons. As long as a mother is living for the fulfillment of her child's every whim, he isn't experiencing frustration, and he isn't learning fear, anxiety, or stress. She is taking it all away from him. His life is nothing but a big bowl of cherries. That's nice but, unfortunately, when he graduates to the real world, he will find that there are few cherries to be eaten and that he must cultivate the cherry tree all by himself."



Dr. and Mrs. Sanford Matthews relax at their home while discussing his new book, ***Through the Motherhood Maze.***

Along the same line, he emphasizes that eventually every human being will be faced with stressful situations, but they will come without the back-up benefit of his indulgent mother by his side. "The older he is, the harder the lesson will be to learn," Dr. Matthews declares. "And he will probably be taught in a much more hostile environment than his own home . . . instead of a mother's kiss on the cheek for his failure to cope, it will be someone else's kick in the rear, a sneer or a jarring remark."

To the mother who states that she doesn't want to "break his spirit" by such seemingly harsh treat-

* Mrs. Gay is the corresponding secretary and former historian of the Auxiliary of the MAG. Send reprint requests to her at 911 Vistavia Circle, Decatur, GA 30033.



The opera-loving Dr. Matthews has a dog named Tosca who sings for visitors.

ment as Dr. Matthews sometimes suggests for her child, he has this to say: "I don't really believe that a loving mother can ever break her own child's spirit. I will tell you, though, that a child can break a mother's spirit."

He encourages every mother to strive to be "a somebody" in addition to being a mother. She doesn't have to run off to California to "find herself," he says to those who are always looking for the "real me." If she does, she won't find herself in California because she's right there "in New Jersey, or Illinois, or Georgia." All she has to do is "put her hands in her pockets, her mind on her heart's desire, and take some rightfully earned time to think, to enjoy and be, every single day."

He believes firmly that "the children of distressed and frustrated mothers frequently have behavior problems — they can become the picky eaters, the class bully, the young hypochondriac."

The fathers of his patients are never left out of Dr. Matthews' considerations. Fathers are important too, he says, but it is the mother who does the most to set the child's sails in the right direction. Nevertheless, he often includes husbands in his counseling sessions.

Dr. Sanford Matthews, called Sandy, is a native of South Orange, New Jersey. He attended high school in New York City by commuting every day to Manhattan. Entering Holy Cross College in Worcester, Massachusetts, after high school, he completed 3 years of pre-medical training in 2 years and entered Cornell University's medical school at the age of 19 years, where he was graduated and named to Alpha Omega Alpha. Two years of internal medicine came next at New York Hospital, followed by 3 years in the Navy and a Harvard University teaching fellowship spent at the Children's Medical Center in Boston, and a period of 1 year as a Harvard exchange resident at St. Mary's Hospital in London.

He was at one time stationed at Dobbins Air Force Base in Marietta, and during this period made ward rounds at Grady Hospital. For three and a half years he was acting chief at Old Egleston Children's Hospital on Forrest Road, where he also spent 17 years in diagnostic neurology. He has been, among many other things, a consultant to the Third Army, a visiting professor at the Medical School of the University of New Mexico, a clinical professor at the Emory University School of Medicine, and president of the local Visiting Nurses Association, of which he is a board member. Last year, he appeared on the Charlie Rose Talk Show.

Dr. Matthews is married to the former Helen Beaudry, of Atlanta, and they have four children.

Maryann Bucknum Brinley, his collaborator on the book, has been an editor of *Ladies Home Journal, Good Housekeeping,* and *Woman Magazine.* She is currently a free-lance writer, a contributing editor at *Health* magazine, and the editorial director of *New Mother News,* a newsletter for pregnant women and new mothers in the New York metropolitan area. She is married to Bob Brinley and is the mother of two young children.

The inevitable question is: How did the two get together to write a book? She was working as a stringer for *Newsweek* and was looking for a one-liner on Little League Football. She read a line in *Family Health* which had been credited to Dr. Matthews. The mother of a 7-month-old child at that time, she called him to discuss her difficulties in "staying herself" while caring for a young child, and the conversation branched into a plan for putting their thoughts into a book. He previously had considered writing such a book and had taped many notes from counseling sessions with patients. Before anything could materialize, however, he had found himself quoted in several other magazines, and one of these quotes had been picked up by an editor at Doubleday who contacted him with the same idea. The new book is a result of many months of dealings with publishers and editors.

The manuscript was rewritten and revised several times, and the final version includes an epilogue called "The Art of Sandy Matthews, M.D.," written by Mrs. Brinley, and 22 serious and sometimes humorous "Maxims According to Matthews."

Subsidiary rights already have been taken up by several interested people. *Redbook* has bought rights to the whole book, and *Self* magazine has bought one chapter. The October issue of *Redbook* has an article about Dr. Matthews and his book.

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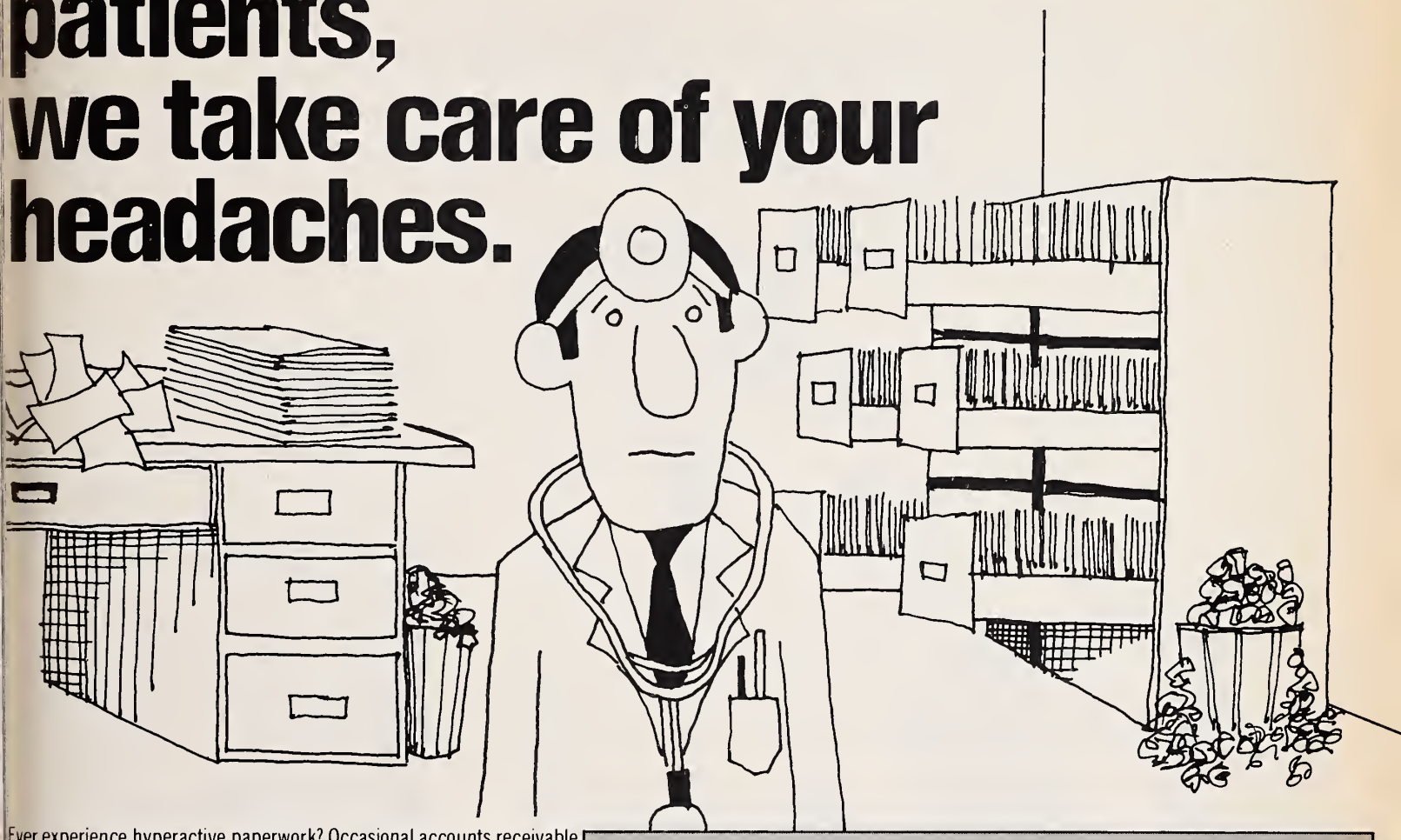
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Allergy — Clinical Immunology or Gimick?

ALLERGY HAS BEEN DEFINED as an "untoward physiologic event mediated by a variety of different immunologic reactions."[1] Although this is somewhat simplistic, there are three very definite implications. First, one must exactly define the antigen or allergen causing the allergic reaction. Secondly, a causal relationship between the exposure to the antigen and the occurrence of the lesion or symptom must be demonstrated. Lastly, specific identification of the immunologic mechanisms involved must be shown. Although this may sound overly simple, it is quite another thing to determine clinically these specific associations in a given patient.

Now that we have defined *allergy,* let us proceed to the *allergist.* The American Board of Allergy and Immunology, in their 1979 publication,[2] specifically outlined the accepted qualifications and proper training of an allergist. Although I will not repeat all of the definition, suffice it to say that a certified specialist in allergy and immunology has had training in internal medicine, pediatrics, or other specialties, followed by Board certification. This is followed by 2 years in a certified allergy/immunology training program and Board certification in allergy. During these 2 years of specialty training, the allergist has highly technical education in methods of diagnosis, treatment, and prevention of allergic diseases. He is also exposed to training and knowledge in many related areas such as asthma, pulmonary physiology, dermatology, allergic gastro-intestinal disorders, etc.

The author describes the approved training for Board certified allergists and warns against employing the services of persons trained at "quickie" courses.

In addition, the certified specialist becomes familiar with the myriad of new immunologic disorders, laboratory techniques, and reconstitution procedures which are so prevalent in today's literature and practice. I mention this in some detail, because the subheading "Allergist" in the phone book or the name plate on a physician's door may or may not encompass the above training procedures and requirements. In this day and age we have a number of what I will call "alternative allergists." Abbreviated allergy courses lasting from 3 to 7 days have become available. These workshops usually train the physician or paraphysician in some of the less well defined areas of allergy. As one can tell from the previous paragraph, this type of quickie training is hardly comparable to the Board certification program. However, such alternative training may lead to the title of "Allergist" although, again, not as defined by The American Academy of Allergy.

Before visiting an allergist or prior to referring a patient to an allergist, the patient, as a consumer and allergy sufferer, and the referring doctor should avail themselves of information regarding allergy specialty training as it refers to the given physician in their community. The practicing allergist is literally deluged

with new clinically pertinent immunologic information which is applicable to patient care. In my opinion, the Board certified or fully trained allergist is much more likely to translate this information into good patient care.

A word about a few of the alternative procedures used by some of those who call themselves allergists. Cytotoxicity testing, urine autoinjection, skin titration (Rinkel method), provocative and neutralization testing (subcutaneous), and provocative testing (sublingual) are all methods employed. In the recent position statement published in the *Journal of Allergy and Clinical Immunology* by The American Academy of Allergy Committee, the following conclusions were drawn.[3]

Cytotoxicity testing and urine autoinjection were shown to have no basis in experimental fact. The Rinkel method has been shown to be no more effective than placebo as immunotherapy, and subcutaneous and sublingual provocative testing cannot be shown effective in doubleblind studies and are accepted as experimental only. Office allergy skin testing followed by skin test interpretation and allergy extract preparation by a third party (usually commercial) at a distant site is unacceptable. This practice completely bypasses the history and physical examination and other important facets of the diagnostic work up. The patient is then subjected to immunotherapy with antigens selected by the third party who is in no way involved in their health care. This technique should be discouraged and, indeed, condemned.

In summary, allergy/immunology is now a well recognized clinical subspecialty whose practice is based on a large and ever increasing mass of immunologic and other scientific information. The patient and referring physician should avail themselves of a specialist who is thoroughly trained and most able to bring these tools to bear upon the clinical problems we face now and in future years.

Donald C. McLean, M.D., FAAA, FACA, FAACIA
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An Editorial Background — The FTC and the Medical Profession

The Issue: Congress is considering whether the Federal Trade Commission has jurisdiction over state-regulated professionals, including physicians.

The Senate Commerce, Science, and Transportation Committee has reported a bill (S. 2499) saying that the FTC has no jurisdiction over state-regulated professions or their professional associations, that it lacks authority to issue rules affecting them, and prohibits FTC preemption of state laws relating to members of the professions.

The House bill (H.R. 6995) dealing with the FTC does not carry language concerning the professions, but an amendment is expected to be offered along the lines of the Luken-Lee bill (H.R. 3722) which would place a moratorium on FTC action on the professions until Congress specifically gives it permission.

The History: The FTC first attacked the ethical principles of a professional

association when it issued a complaint against the American Medical Association in December, 1975, charging that it was engaged in anti-competitive activities and that it prohibited advertising, solicitation, and contract practice by physicians. The litigation went on within the FTC system until the full Federal Trade Commission issued its order and opinion in the fall of 1979 against the AMA and through the AMA to state and county organizations. This was appealed to the U.S. Court of Appeals and then to the Supreme Court, which on March 23, 1982, had a split (4-4) vote resulting in upholding the FTC strictures.

During this process, the issue was raised in Congress in 1977, which then denied the FTC jurisdiction over the professions. It was revived again in 1982 after the Supreme Court action, and is now pending before the Congress.

Myths and Facts

MYTH #1: The American Medical Association Prohibits Advertising

FACT: The AMA position is: "A physician may publicize himself as a physician through any commercial publicity or other form of communication (including any newspaper, magazine, telephone directory, radio, television, or other advertising), provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive." There are no restrictions on fee information.

MYTH #2: Only the FTC Broke an Advertising Ban

FACT: AMA policy did not in 1975 prohibit advertising, but in the interest of protecting the public from unfair and misleading practices, sought to discourage false and misleading solicitations. It was the interpretation of the word "solicitation" that was at issue, and the AMA clarified its position in 1976 in language that complies with the FTC mandate, and was acceptable to the Supreme Court in 1977. The FTC ignored this and refused to consider this information during legal proceedings which continued for seven years.

MYTH #3: AMA Codes Barred Doctors From Working for Pre-Paid Health Maintenance Plans

FACT: AMA policy supports neutral public policy and fair market competition among all health care delivery systems. It also holds that the growth potential of HMOs should be determined by people's preference rather than government preference, e.g. subsidy.

MYTH #4: The FTC Is Encouraging Practices That Will Cut Health Care Costs

FACT: The opposite is true. A recent decision by the FTC has told one state medical society that it should no longer initiate or participate in health cost containment talks with the state's Medicaid program. Physicians no longer will be able to participate in voluntary citizens' cost containment commissions, since this is viewed as collusive or price-fixing activity by the FTC.

MYTH #5: Doctors Want to Be a Privileged Elite Class That Is Immune From Enforcement of Laws That Affect Everyone Else

FACT: The medical profession is by no means putting itself above the law and to say so is reckless and damaging. To the contrary, the profession is subject at all times to extensive state and federal regulatory and oversight authority, including U.S. Department of Justice, state, and private antitrust enforcement authority. It also is subject to widespread civil litigation.

MYTH #6: Professional Associations Limit Entry Into the Practice of Medicine

FACT: The AMA has been supportive and active in accrediting and increasing the number and size of medical schools, which have increased from 103 to 126 in

the last 10 years, with graduates going from 8,974 to 15,667 over the same time.

MYTH #7: The AMA Does Not Believe That the Market Should Determine the Number and Distribution of Physicians

FACT: The AMA has clear policy supporting the marketplace concept of manpower distribution for total numbers of doctors, specialty practice, and geographic location.

MYTH #8: Medical Associations Stifle Innovative, Cost-Cutting Health Care Delivery Systems

FACT: There are no prohibitions on place or form of care. Medical associations do, and will, however, maintain high standards on quality of care and the protection of the public from the unskilled or unqualified. The AMA has been engaged over a number of years in a wide range of voluntary activities to make delivery of health care more cost effective, including recommendations for greater marketplace choice for consumers and balanced insurance coverage for care given outside the hospital.

MYTH #9: Doctors Are Responsible for the Rise in Health Care Costs Over the Past Decade

FACT: Physicians' services account for 18% of the health care dollar, the rest going to hospital, laboratory, equipment, and other aspects. In fact, the physician services portion of the consumer price index has increased less than the all services index. That is why physicians' participation on cost containment coalitions is so essential, since they have the most knowledge about these other elements.

MYTH #10: The Federal Trade Commission Will Deal Only With Business and Competition Aspects of Medical Care

FACT: FTC activities already have directly damaged quality of care by limiting physicians' and medical societies' ability to enforce professional standards, engage in peer review, and comment on poor performance records in the practice of medicine. Activities carried on by medical societies, including establishment of standards, continuing education, and the impaired physician program are threatened by the loss of funds diverted to accommodating FTC fishing expeditions.

In addition, despite protestations to the contrary, if the FTC proceeds on the course it is taking, agency bureaucrats will have to engage in making value judgments on quality of care as that quality relates to marketplace elements. The FTC is not equipped for any of these tasks.

Edgar Woody, Jr., M.D.

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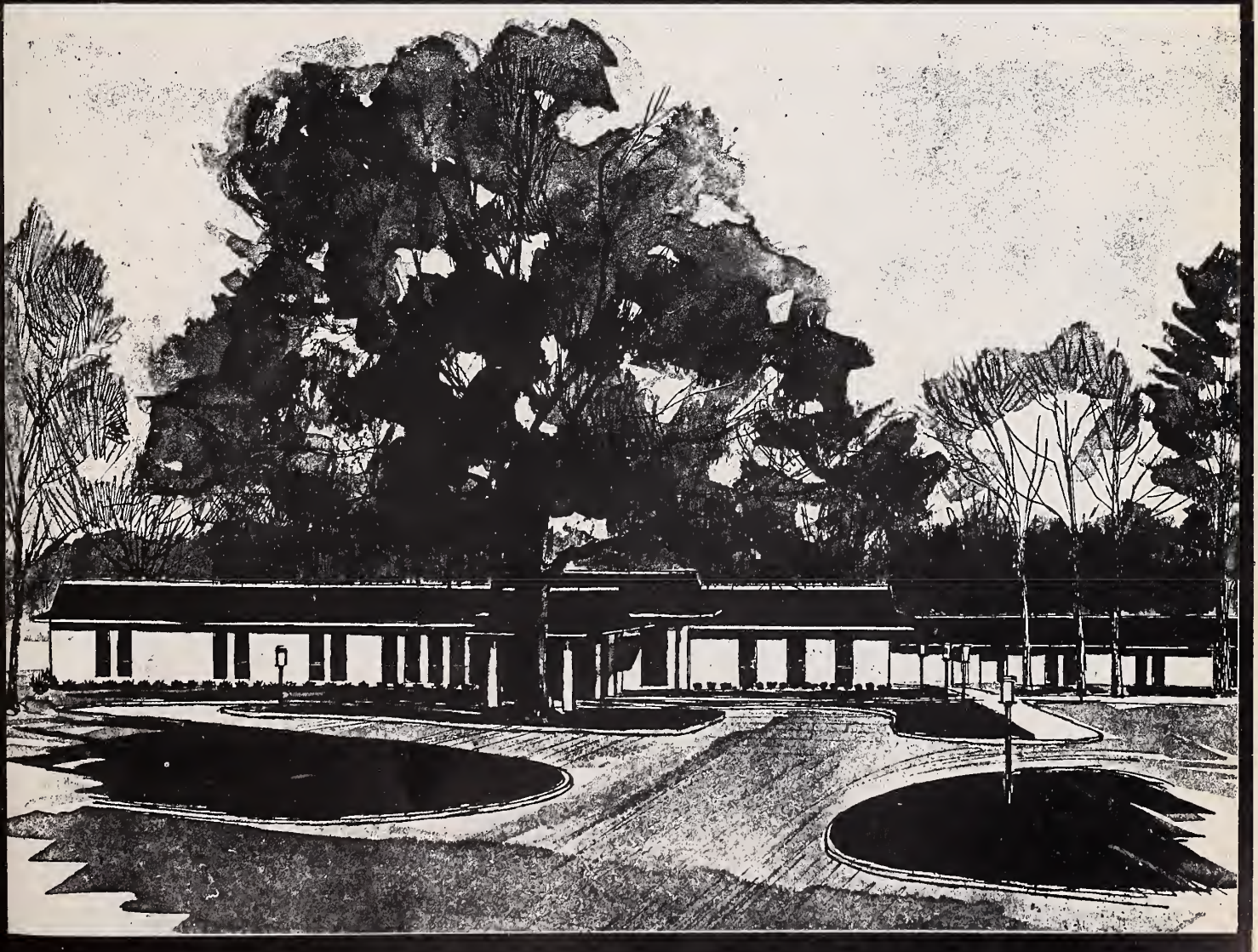
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*Please see following page for Brief Summary of Prescribing Information.



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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG.

CONTRAINDICATIONS

1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE: In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levarterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY: Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. *Central Nervous System:* lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. *Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. *Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. *Respiratory:* bronchospasm. *Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. *Miscellaneous:* reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. *Clinical Laboratory Test Findings:* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

TABLETS
—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).
—Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).
—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).
—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).
The appearance of these tablets is a trademark of Ayerst Laboratories.
Store at room temperature (approximately 25° C).
INJECTABLE
—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).
Store at room temperature (approximately 25° C).

7997/882

Reference: 1 Freis, E.D. Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981

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Utilization and Quality Control Peer Review Organizations — A Rose By Any Other Name . . . ?

ROBERT N. BERG, *Atlanta**

THE PRESENCE OF the federal government in the area of quality assurance and peer review activities with respect to the provision of health care services has evolved over a number of years. For example, the legislation enacted by Congress in 1965 and 1967 establishing the Medicare and Medicaid programs included provisions requiring utilization review for all Medicare and Medicaid patients.[1] As a result, utilization review committees were established both within health care institutions and by outside organizations, such as medical societies and foundations for medical care, for the purpose of evaluating the medical necessity of health care services financed under the Medicare and Medicaid programs.

Following passage of the Medicare and Medicaid legislation, experiments with various types of innovative utilization review systems were undertaken throughout the country. For the most part, these experiments involved private programs designed to bring about quality and utilization review of medical services. Government involvement in quality assurance activity continued, however, such as through federally funded entities known as "Experimental Medical Care Review Organizations," which, in contrast to utilization review, were designed to develop and test objective mechanisms for reviewing medical care.[2]

The perceived success of these experimental systems prompted Congress, on October 30, 1972, to establish the Professional Standards Review Organization (PSRO) program.[3] The purpose of the PSRO legislation was "to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made . . . under [the Social Security Act]. . . ." The impetus for adoption of the PSRO program was congressional concern over rapidly rising costs of the Medicare and Medicaid programs and the congressional finding that this increase in cost was caused, in part, by unnecessary use of medical services under the programs. In order to assist in stemming these rising costs, PSROs were established to review the appropriateness, medical necessity, and quality of health care services funded through federal programs.[4]

Subsequent to its enactment in 1972, the PSRO program was subjected to criticism, primarily because studies undertaken to determine the effectiveness of the PSRO program in reducing health care costs had produced mixed results — at best, it appeared that some PSROs had been ineffective, while others had been successful in reducing health care costs.[5]

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

In response to these concerns, Congress enacted the Tax Equity and Fiscal Responsibility Act of 1982, which President Reagan signed into law on September 3, 1982.[6] Included among the provisions of this Act was Subtitle C, known as the "Peer Review Improvement Act of 1982" (the Act), which repealed the existing PSRO statute (the PSRO Statute) and substituted a program requiring the Secretary of the Department of Health and Human Services (the Secretary) to enter into contracts with entities known as "Utilization and Quality Control Peer Review Organizations" (UQCPROs). The congressional purpose in enacting the Act was to replace the PSRO program, with its detailed requirements and procedures, with a more "private sector oriented" system under which the federal government purchases review services from peer review organizations under negotiated contracts.

In order to facilitate UQCPRO activities with regard to "private" reviews, the Act requires that health care providers release patient data to an UQCPRO upon request.

It will be some time before regulations are adopted setting out the specifics concerning the UQCPRO program. As a result, it is difficult to determine at this time whether the repeal of the PSRO program and creation of the UQCPRO program represents a change merely in form or in substance. Nonetheless, based upon a comparison of the Act and its predecessor, the PSRO Statute, it appears that there may be several important differences between PSROs and UQCPROs:

Qualifying Entities

PSROs were required to be non-profit organizations having a substantial number of area physicians as members. Membership in a PSRO was required to be "open," such that all eligible physicians could become PSRO members. PSROs were also required to be unaffiliated with medical associations.

Under the Act, the organizational requirements for UQCPROs differ from those imposed under PSROs. First, UQCPROs may be non-profit or for-profit entities, a change which obviously will have the effect of increasing the number of eligible review organizations. On the other hand, UQCPROs not only must have a substantial number of area physicians as members but also must have a membership representative of the practicing physicians in the appropriate geographic area (or, alternatively, have available through some type of arrangement the services of physicians necessary to assure adequate peer review). Moreover, UQCPROs may not be third-party payors, at least during the first 12 months in which the Secretary seeks to enter into UQCPRO contracts; nor may UQCPROs be, or be affiliated with, hospitals or other health care facilities, although the Act allows an UQCPRO to subcontract with a hospital or other health care facility.[7]

Geographic Area

One of the expressed purposes of the Act is to consolidate the geographic areas which had comprised the PSRO areas. To do so, the Act provides generally that each State shall be designated as an UQCPRO area. The Act also contains certain minimum criteria pursuant to which the Secretary may establish local or regional UQCPRO areas: (i) any State having fewer than 180,000 Medicare and Medicaid hospital admissions annually must be established as a single statewide area; and (ii) no local or regional area may be established by the Secretary which has fewer than 60,000 total hospital admissions (including public and private patients) under review annually, unless the Secretary determines that other relevant factors warrant otherwise.[8]

UQCPRO Functions and Performance

PSROs were designed to review the medical necessity, quality, and appropriateness of health care services. Under the Act, UQCPROs are given a fourth function: To review the *reasonableness* of those services.

In order to perform their functions, UQCPROs are expressly authorized to undertake certain activities which were not authorized by statute to be performed by PSROs, including: (i) undertaking professional inquiries, either before or after (or both) the provision of services, to the extent that the UQCPRO believes that such inquiry will facilitate its activities; (ii) examining the pertinent records of any practitioner or provider of health care services with respect to which the UQCPRO has a responsibility for review; and (iii) inspecting the facilities of any practitioner or provider of health care services in which care is rendered or services are provided with respect to which the UQCPRO has a responsibility for review.[9]

"Private Reviews"

The PSRO statute was silent as to the performance of "private" reviews (e.g., reviews involving services for which reimbursement is made by private third party payors) by PSROs; the PSRO Regulations and Program Manual, however, indicated that PSROs could undertake "private" reviews as long as they did not interfere with the performance of PSRO responsibilities. The Act, on the other hand, expressly requires that an UQCPRO make available its facilities and resources for contracting with private and public entities paying for health care in its area, for review, as feasible and appropriate, of services reimbursed by such entities. Moreover, the Act authorizes UQCPROs to review Medicaid claims and provides that the federal government will pay 75% of the expenditures made by the State Agency to the UQCPRO. The Act also encourages increased utilization review by fiscal intermediaries.[10]

In order to facilitate UQCPRO activities with regard to "private" reviews, the Act requires that health care providers release patient data to an UQCPRO upon request. This requirement relates both to requests made so as to allow the UQCPRO to perform its duties under its contract with the Secretary and to requests made so as to allow the UQCPRO to perform its duties under private review contracts; as to the latter category, however, providers are only required to release information as to patients who authorized the release for the purpose of UQCPRO review.[11]

Immunity

Under the PSRO Statute, members or employees of PSROs were immune from civil or criminal liability in connection with services provided to or rendered on behalf of the PSRO, provided that the member or employee exercised due care and that the actions taken by the member or employee were not motivated by malice. The immunity section of the Act tracks the language of the PSRO Statute, with two exceptions: First, in addition to immunizing actions taken by employees and members providing services to an UQCPRO, the Act also provides immunity for persons having a fiduciary relationship with the UQCPRO; and, second, the Act does not require that the person seeking immunity, in addition to exercising due care, act without malice toward any other person or entity.[12]

Disclosure of UQCPRO Data and Information

The Act expressly exempts UQCPROs from the provisions of the Freedom of Information Act (FOIA). Previously, a lower court had determined that the provisions of the FOIA were applicable to PSROs, as a result of its finding that a PSRO was a "federal agency" within the meaning of the FOIA. Although this opinion was subsequently reversed on appeal,[13] it nonetheless was unclear as to whether PSROs would be required to comply with the disclosure requirements contained in the FOIA. The Act now answers that question by exempting UQCPROs from the FOIA disclosure requirements.

On the other hand, the Act substantially expands the instances in which an UQCPRO is required to disclose confidential information. For example, in addition to disclosing confidential information in order to assist federal and state

agencies in identifying cases of fraud and abuse (as PSROs formerly were required to do), an UQCPRO must also disclose information: (i) to assist appropriate federal and state agencies recognized by the Secretary as having responsibility for identifying cases or patterns involving risks to the public health; (ii) to assist appropriate state agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners; and (iii) to assist the Secretary and appropriate federal and state agencies recognized by the Secretary as having health planning or related responsibilities under federal or state law (such as health systems agencies and state health planning and development agencies). The Act expressly provides that an UQCPRO may require payment of a reasonable fee for providing such information in response to a request.[14]

Effect on Existing PSROs

The Act provides that the Secretary may not terminate an existing PSRO arrangement (in existence as of September 3, 1982) until such time as he has entered into a contract with an UQCPRO covering the same geographic area. Thus, presently functioning PSROs may continue to do so until the expiration of their current contracts, unless the Secretary enters into an UQCPRO contract for the particular geographic area involved prior to the expiration date, at which time the PSRO contract will automatically terminate.[15]

Summary

The Act appears to embody the same assumptions as those serving as the basis for the adoption of the PSRO program — that health care professionals are the most appropriate individuals to evaluate the quality of medical services and that effective peer review at the local level is the soundest method for assuring the appropriate use of health care resources and facilities. At the same time, however, the Act may be viewed as an extension into the health care area of President Reagan's philosophy of reduced government involvement: While the PSRO program imposed a detailed regulatory scheme upon the performance of PSRO review activities, the Act leaves determination of the UQCPRO performance standards to negotiation between the Secretary and the UQCPRO, relying upon the Secretary to establish "negotiated objectives against which the [UQCPRO's] performance will be judged." Only time will tell, however, whether these changes in form will result in an increase in the effectiveness of peer review activities in reducing health care costs.

Notes

1. See, generally, 42 U.S.C. §§1395 *et seq.* (Medicare) and 42 U.S.C. §§1396 *et seq.* (Medicaid).
2. See, S. Rep. No. 92-1230, 92d Cong., 2d Sess., 264 (1972).
3. Pub. L. 92-602, 42 U.S.C. §1320c *et seq.*
4. See, S. Rep. No. 92-1230, 92d Cong., 2d Sess., 254-255 (1972).
5. See, e.g., Pub. L. 97-35, the 1981 Omnibus Budget Reconciliation Act, which authorized the Department of Health and Human Services to terminate ineffective PSROs.
6. H.R. 4961.
7. Social Security Act, §§1152, 1153 (Act, §143).
8. *Id.*, §1153(a)(1), (2).
9. *Id.*, §1154 (a)(1), (7).
10. *Id.*, §§1154 (a)(11), 1158.
11. *Id.*, §1866(a)(1) (Act, §144).
12. *Id.*, §1157.
13. See, *Public Citizen Health Research Group v. Department of HEW*, 477 F.Supp. 595 (D.C. D.C. 1979), reversed on appeal, 668 F.2d, 537 (D.C. Cir. 1981).
14. Social Security Act, §1159.
15. Act, §150(a), (b).

The Role of Cryotherapy in the Treatment of Oral Cancer

HARVEY SILVERMAN, D.D.S., M.S., *Lilburn**

ALTHOUGH CRYOSURGERY has been employed over the last 3 decades to treat a variety of tumors both benign and malignant, its role in the treatment of oral cancer remains controversial. The purpose of this article is to relate the author's experience with this modality and to review the literature.

Method of Application and Action

Although the lowering of a tissue's or a cell's temperature produces profound biochemical and physiologic changes, the changes are usually reversible.[1] In order to produce nonreversible change, a review of the pathophysiology of tissue destruction by freezing is in order. If the temperature of a tissue is lowered slowly (1C/min.), ice forms extracellularly, thus increasing the vapor pressure within the cell causing intracellular water to leave. This is maximal between −5 C and −50 C. Below −50 C, no further effect is seen. As the cell becomes dehydrated, the intracellular electrolyte concentration increases and poisons the cell's enzyme system.[1] The cell is thus damaged from without by extracellular ice formation and from within by the concentration of the cell's constituents. Although effective, this process does not produce optimum tissue damage and cell death. To create the maximum amount of damage, the tissue must be cooled rapidly (100 C/min.).[1] When this occurs, intracellular water is trapped, and the tissue undergoes both intracellular and extracellular freezing. A combination of rapid cooling and slow warming produces large ice crystals and maximizes tissue damage and cell death.[1-3]

In the clinical setting, therapists using cryosurgery must be aware of the relationship between the size of the cryoprobe, the cryogen agent, and the vascularity of the tissue to be treated. The larger the probe, the more rapidly the temperature of a tissue can be reduced.[2] Liquid nitrogen is the most effective cryogen, because it has a boiling point of −196 C; however, it is difficult to obtain and has a very short shelf life.[2] Nitrous oxide, on the other hand, is much easier to use and has a long shelf life. Its boiling point, however, is only −90 C, so it does not have the ability to reduce the temperature of large areas of tissue as rapidly.[3] This necessitates more freeze-thaw cycles to adequately treat larger areas. Lastly, the greater a tissue's vascularity, the greater is its heat sink; therefore, it is more difficult for a cryogen to reduce rapidly that tissue's temperature.[1, 2]

In order to enable the therapist to better assess his treatment, thermocouples should be placed throughout the tissue to be treated. The use of thermocouples is an effective way to insure adequate treatment of the diseased tissue.[1]

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Repetitive freeze-thaw cycles increases tissue ischemia and further enhance the cryogen's ability to lower temperature as monitored by the thermocouples. Other factors to be considered when cryotherapy is to be used are: the accessibility of the area to be treated and the ability of the therapist to determine the tumor's boundaries.[2]

Over the last 8 years, the author has limited his use of cryotherapy for the treatment of oral cancer to two areas: (1) diffuse premalignant mucosal lesions of the mouth (atypia to cancer in situ), and (2) recurrent disease unresponsive to conventional therapy.

Report of Cases

Case 1: A 56-year-old white woman was referred for the evaluation of diffuse leukoplakia of the anterior floor of her mouth which she had been aware of for the past 17 years. The patient had smoked two packs of cigarettes per day for over 30 years and had used alcohol socially. The remainder of her medical history was unremarkable. The lesion consisted of a white thickened area extending across the ventral surface of her tongue and covering the entire anterior floor of her mouth, including the plica of both submaxillary ducts and the lingual mucosa covering the mandible. The lesion extended posteriorly into the retromylohyoid spaces bilaterally (Figure 1). Multiple biopsies of the affected areas revealed moderate atypia with no evidence of frank malignancy. The patient was advised to refrain from smoking and was treated with cryotherapy. In February, 1978, cryotherapy was begun, using the Frigitronics nitrous oxide unit. In order to adequately cover the area, several appointments were necessary. Other than localized swelling, the recovery period was uneventful. The patient has been followed closely, and as of her last appointment in January, 1982, has been free of residual or recurrent disease (Figure 2).



Figure 1 — Pretreatment leukoplakia of the floor of the mouth (left) and ventral surface of the tongue (right).

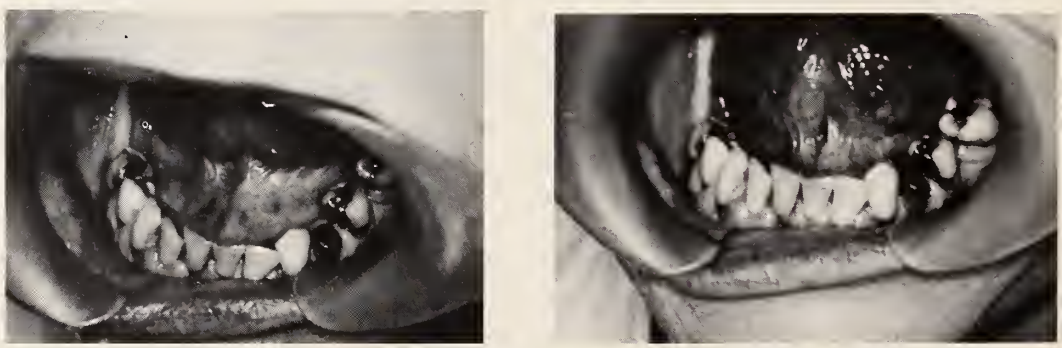


Figure 2 — Floor of the mouth (left) and ventral surface of the tongue (right) following cryotherapy.

Case 2: A 40-year-old black woman presented in August, 1978, with an exophytic mass extruding from the tuberosity of her right maxilla. Biopsy of the area revealed squamous cell carcinoma. The patient's presurgical work up revealed that the tumor was emanating from the right maxillary sinus. No evidence of distant disease was identified. The treatment plan included a right hemimaxillectomy with

immediate reconstruction, utilizing a maxillary stent and post-operative radiotherapy. This procedure was carried out in September, 1978. The patient was followed closely, and a permanent obturator was constructed for her. In April, 1979, a mass was identified in the defect of the right cheek. Biopsy revealed recurrent squamous cell carcinoma. In May, 1979, this area was reexcised, and the patient did well until September, 1979, when the carcinoma recurred in the right cheek. Following a full course of chemotherapy, there was only slight resolution of the tumor (Figure 3). In January, 1980, cryotherapy was used to treat the residual tumor. Several appointments were necessary for adequate treatment, and complete resolution of the tumor was obtained. In February, 1980, a mass was palpated in the right neck. In March, 1980, a right modified neck dissection and postoperative radiotherapy were carried out. The patient tolerated the procedure well and has been followed closely since. On her last appointment in June, 1982, no evidence of recurrence at the primary site or distant disease was identified (Figure 4).

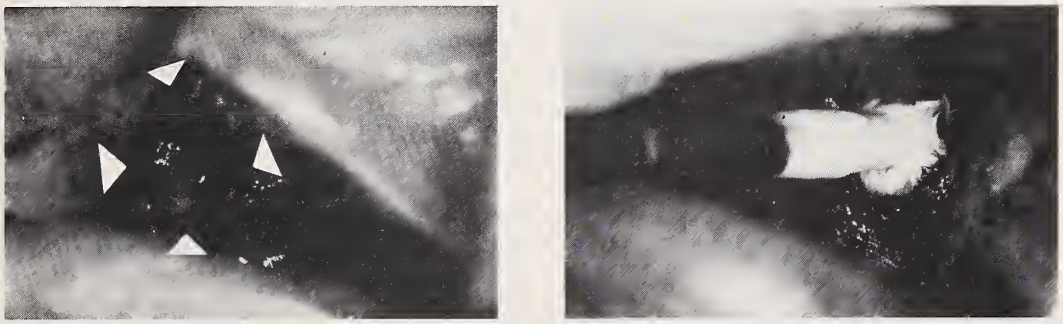


Figure 3 — (left) Recurrent tumor in hemimaxillectomy defect, arrows. (right) Cryosurgical probe freezing tumor.



Figure 4 — Hemimaxillectomy defect devoid of tumor following cryotherapy.

A Review of the Literature

In general, cryotherapy has been used on several groups of patients: 1. those with malignant oral tumors treated for cure, 2. those with malignant oral tumors treated for palliation, 3. those with superficially invading and diffusely spreading premalignant oral lesions, and 4. those being treated experimentally.

With regard to the treatment of oral cancer for cure, Smith and Weaver[4] reported 90 percent local control in 50 patients over a 2-year period in T1-T3 lesions of the mouth. DeSanto[2] used cryotherapy for cure in patients whose lesions were accessible and who either refused surgery or whose underlying medical condition was so bad as to preclude the use of a general anesthetic. Out of eight patients treated, three were alive 2 years after treatment. Three patients died of second primary cancers, and one patient died of natural causes. One patient died of postoperative hemorrhage secondary to cryotherapy. Gage[5] reported the use of cryotherapy for cure in 49 patients from 1964-1968. In a group of 25 patients with T1-T3 lesions followed over 2 years, 17 were alive without disease. Three patients died of unrelated disease, and four died from recurrent neck disease or distant metastases. One patient died of persistent local disease. In general, it appears that cryotherapy for

cure is limited to patients who have tumors that are superficial and accessible and who either refuse surgery or whose underlying medical condition precludes conventional treatment.

The use of cryotherapy to palliate patients with large tumors unable to be cured surgically, radiotherapeutically, or through both modalities has been disappointing. Both Gage[5] and DeSanto[2] related temporary pain relief and a debulking of large tumors utilizing cryotherapy. Although pain relief occurred, it was only temporary. Complications were significant and occurred primarily in patients who had undergone irradiation prior to the use of cryotherapy. These complications included oral cutaneous fistula, osteoradionecrosis, serious hemorrhage, and obstruction of the airway.[2, 5]

In the treatment of diffuse premalignant mucosal disease (mild atypia to carcinoma in situ), Sako[6] and Gongloff[7] felt that cryotherapy offered certain advantages, such as ease of use in the outpatient setting, minimal pain, no postoperative bleeding, and little scarring and fibrosis. Both authors related that in a certain percentage of their patients, frank invasive cancers did develop, and they recommended close follow up and the elimination of any underlying habits such as alcohol and tobacco use which contributed to the patient's original problem.

Experimentally, Marciani[8, 9] has shown that the jaws of animals can be removed, frozen in liquid nitrogen (− 196 C), and used as customized trays to carry successful autogenous marrow grafts to restore jaw function and anatomy. Weaver, Plezia, and Cummings have resected malignancies involving the mandible. Following treatment with liquid nitrogen, they were used in conjunction with an autogenous marrow graft to reconstruct the resected jaw.[10-12] The results, although encouraging, need further investigation.

Discussion

The use of cryotherapy remains a controversial modality in the treatment of oral cancer for cure. The lack of a surgical specimen on which to evaluate margins, the inability to adequately treat the large inaccessible lesion, the associated complications, and the necessity to handle the status of the neck surgically, radiotherapeutically, or by both means remain as arguments against this form of therapy. On the other hand, the ability to preserve form and function and to treat the medically compromised patient is an incentive to keeping an open mind with regard to the use of cryotherapy in the carefully chosen patient. The author has limited his use of cryotherapy to diffuse premalignant lesions established by biopsy. Treatment of such diffuse lesions by surgery or electrodesiccation exposes the patient to significant morbidity. In the author's experience, cryosurgery has offered this group of patients an effective means of treatment that preserves normal nerve and salivary gland function with little distortion of local anatomy. All patients treated by this modality have been followed closely and have no evidence of frank malignancy. In addition, the use of cryosurgery in the treatment of recurrent cancer that has been unresponsive to conventional modes of therapy has been utilized. It is the author's belief that this form of treatment offers the head and neck therapist a worthwhile option in carefully chosen cases.

Acknowledgements

I wish to thank Drs. Albert A. Clairmont, Benjamin Hill, Guler L. Karcioglu, and Thomas W. Phillips for their contribution to the treatment of Case 2.

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Cardiovascular Depressant Effects of Anesthetic Agents and Potential Drug Interactions

ROBERT J. ADAMS, Ph.D., P. STEVEN MOTE, M.D., and JACK K. PRUETT, Ph.D., *Augusta**

ALTHOUGH GENERAL ANESTHESIA is considered by many of the non-anesthesiologist medical community to be a rather simple and benign process, one of the most basic and perhaps best documented effects of inhalation and intravenous anesthetics is their capacity to depress myocardial function and cause systemic hypotension. These effects are not infrequently associated with an enhanced tendency for cardiac arrhythmias, and in particularly susceptible patients, general anesthesia can result in death due to cardiovascular collapse. These dangers of anesthesia exist for all surgical patients including normal, healthy individuals undergoing an elective procedure. However, the dangers and the additional cares to be taken are multiplied several fold in patients with multiple medical problems which could render normal physiologic compensatory mechanisms inadequate during anesthesia. There also exists the very probable danger of severe complications arising from the interaction of anesthetic effects with those produced by a variety of other drugs commonly prescribed for cardiovascular or other medical problems. Though all organ systems could potentially suffer due to these interactions, this article will focus on drug interactions that affect the cardiovascular system.

Several aspects concerning general anesthesia and the cardiodepressant actions of the anesthetic agents should be addressed before discussing the potential drug interactions. The ability of anesthetics such as halothane, enflurane, fentanyl, and others to reduce myocardial contractility and blood pressure is often not appreciated in the healthy patient. Primary reasons for this include (1) the existence of physiologic compensatory mechanisms which counteract the depressant anesthetic effects, (2) the expertise of the anesthetist in preoperative evaluation and intraoperative support of the patient, and (3) the appropriate use of sophisticated and reliable intraoperative monitoring equipment, most of which is devoted to on-line monitoring of cardiovascular parameters. In many patients, only the above second and third factors can be relied upon for a smooth course of surgical anesthesia. This is particularly true for the elderly patient who might be suffering from age-associated cardiovascular disease.

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Advances in surgery, anesthesiology, and internal medicine have increased the median age of the surgical patient and made feasible the undertaking of more and more sophisticated operations in patients whose medical management is complex. These patients typically have significant medical problems not necessarily related to the surgical problem and, in many cases, may be on a multiple drug regimen for a variety of unrelated illnesses. A few of the problems of cardioactive drug therapy in the elderly patient were addressed in a recent issue of the *Journal*.[1]

All drugs capable of producing general anesthesia can have direct as well as indirect depressant effects on the cardiovascular system. Among the major actions of anesthetics, inhibition of sympathetic tone and direct depression of cardiac and vascular smooth muscle are generally predominant factors in reducing cardiac output and blood pressure.[2] Because of the high lipid solubility of the anesthetics, they tend to affect numerous sites of the intra and extravascular space and therefore directly alter cellular function. One potentially significant effect of general anesthetics at the cellular level may be the recently identified ability of these agents to inhibit calcium movement into excitable cells.[3, 4] This effect is of particular importance in consideration of the central role of calcium in the excitation-contraction process of cardiac and vascular smooth muscle. Furthermore, since a variety of other therapeutic agents can also directly or indirectly inhibit calcium influx into excitable cells (see below), the potential for severe cardiovascular depression exists when a patient on such drugs undergoes anesthesia.

The clinical manifestations of the cardiovascular effects of a given anesthetic agent vary quantitatively from patient to patient. These manifestations may also vary qualitatively and quantitatively based on prior drug therapy, adequacy of compensatory mechanisms, and even with the sequence of administration when two or more anesthetic drugs are used in the same patient. The cardiovascular interactions of acutely as well as chronically administered drugs with anesthetic agents may be grouped under one of several mechanistic/physiologic headings.[5]

I. Drugs affecting the autonomic nervous system (e.g., monoamine oxidase inhibitors, tricyclic antidepressants, levodopa, beta-blockers, alpha-blockers, phenothiazines, butyrophenones, guanethidine, alpha methyl dopa, clonidine, reserpine). Drugs grouped here are used to treat a variety of disorders. The influence of these drugs on the management and timing of anesthesia relate to their ability to alter synthesis or uptake of catechol neurotransmitters or to enhance or impair transmitter receptor interactions. All of these drugs alter the responses to anesthetics and other drugs frequently used by anesthetists; many encroach upon cardiovascular reserve or compensatory mechanisms. Some anesthetics such as halothane sensitize the myocardium to catecholamines. Some vasopressors will be more or less effective depending on altered receptor populations and also depending on whether the pressor agent acts directly or indirectly. Some drugs used frequently for premedication are contraindicated by prior use of certain drugs of this group. Some of the drugs in this group require days or weeks for establishment of a stable physiologic state after dosage adjustments. Thus, an elective operation should be planned around the patient and his drug regimen. An emergency operation must be undertaken with full knowledge of the possible drug interactions and with a rational plan for dealing with them when they arise.

II. Drugs affecting fluid and/or electrolyte balance (e.g., diuretics, steroids, lithium, calcitonin). By altering the distribution of body fluids among the various compartments (intravascular, interstitial, or intracellular), drugs in this group may predispose a patient to severe and refractory hypotension when the vasodilation of anesthetic agents is added to a pre-existing volume depletion. Some of these drugs further impair compensatory mechanisms by a direct vasodilating action (steroids, furosemide, thiazides). Further, since the proper function of excitable membranes, whether neuronal or myocardial, is dependent on physiologic electrolyte gradients across cell membranes, these drugs may impair neuroeffector transmission and/or the effector membranes' ability to respond appropriately.

III. Drugs with membrane stabilizing action (e.g., quinidine preparations, propranolol, diphenylhydantoin, local anesthetics). Propranolol belongs in this group as well as the autonomic group since a local anesthetic action is demonstrable. These drugs cause a decrement in excitable membrane function with predictable consequences for the cardiac conduction system in addition to a negative inotropic action on the myocardium.

IV. Smooth muscle relaxants (e.g., nitrates, hydralazine, papaverine, phenothiazines, butyrophenones). This group of drugs predisposes the patient to hypotension, but even more significantly, encroaches upon the compensatory mechanisms of the cardiovascular system. Anesthetics can markedly potentiate the hypotensive effects of these smooth muscle relaxants.

V. Drugs affecting transmembrane ion fluxes (e.g., verapamil, nifedipine, diltiazem). While corticosteroids, furosemide, and acetazolamide might reasonably be placed in this group as well, we focus here on the new group of calcium channel blocking agents, also known as "calcium antagonists." These agents have negative inotropic effects on the myocardium and are extremely potent vasodilators. As previously mentioned, evidence is accumulating to show that at least part of the cardiodepressant action of the volatile anesthetics may be mediated by a disturbance of calcium gating across the cell membrane.[6] It is not unreasonable to anticipate an additive or synergistic response to anesthetics superimposed upon a calcium blocked myocardium. Several reports of such interactions have appeared, although our experience to date does not completely define the range of possible responses.[7] It may be noted that a variety of cardioactive and vasoactive agents, including calcium, can be used to provide cardiovascular support when these agents are used prior to or during anesthesia.

Summary

The potential drug interactions during anesthesia briefly summarized in this article are rarely catastrophic in modern anesthetic practice. However, a smooth course of anesthesia and good postoperative recovery is often dependent upon a careful medical history, a thorough knowledge of the patient's current medical management, and a detailed evaluation of the potential interactions between previously administered drugs, anesthetic agents, and anesthetic adjuvants.

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president's letter



Let's Advertise!

SMALL CHILDREN know the names and characteristics of the major brands of cereal. They watch cartoon shows on TV where manufacturers of cereals advertise their products. Soap and paper producers also advertise extensively. They must, since there is little difference in the quality of the wares offered. It is obvious that these efforts do influence people in their thinking and buying habits.

Medical paraprofessionals are advertising more and more. They, too, must use salesmanship to gain acceptance for services that cannot compete solely on the basis of merit. The fully trained and competent physician stands alone in the quality of care he/she renders.

So, let's advertise also, but let's do it differently. MAG can be the agent. It can develop our image of concern for the health and welfare of the American public. The people must learn that physicians are the authorities on how to become and remain well. They must be confident that this profession, through its peer review processes, will assure that those who present themselves as doctors of medicine will deliver competent care at a reasonable cost. Our advertising must be of the profession. There will be no need to advertise as individual practitioners if this effort is effective.

The MAG Public Relations Committee, under the chairmanship of Dr. Charles McDowell, of Decatur, is developing an intensive public education program this year. The goal of establishing MAG and its members as reliable educators of the public and authorities on all matters that affect the public health is a reasonable goal.

We physicians have a story to tell. We must help the public learn the facts.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.

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PERSONALS

Third District

Paul C. Braun, Jr., M.D., recently opened an office in Montezuma. Dr. Braun has been in practice in Americus for 6 years.

Fourth District

Charles Allard, M.D., has been chosen Medical Director for the Substance Abuse Treatment (SAT) Unit at Decatur Hospital. The new unit is for the treatment of alcoholism and other drug dependence. The 25-bed unit will offer medical detoxification; individual, group and family counseling; educational seminars; and leisure skills counseling, with a 10-week aftercare program and a 2-year follow up available.

Fifth District

Richard W. Blumberg, M.D., who was chairman of Emory medical school's Department of Pediatrics for 22 years, was honored by Children's Hospital in Cincinnati, where he was a research fellow almost 40 years ago. In October, the hospital unveiled portraits of 17 former residents who went on to distinguished careers. At the time of his retirement in 1981, Dr. Blumberg was made Professor Emeritus and was honored by the establishment of the Bartholomew-Blumberg Fellowship Endowment Fund in the College of Medicine.

Edwin C. Evans, M.D., current President of the Southern Medical Association, installed the Association's new officers at SMA's 76th Annual Scientific Assembly held October 30-November 2 at the Georgia World Congress Center in Atlanta. Dr. Evans and all of the officers are honored by being included in *Who's Who in America.*

Dave M. Davis, M.D., has been appointed to the Consultation Services Board of the American Psychiatric Association for five years. This group provides consulta-

tion to the mental health departments of foreign countries, various states within the United States, and to various mental health centers and hospitals around the world.

An Emory University professor of gynecology and obstetrics, **Armand Hendee, M.D.,** is the new president of the Georgia Obstetrical and Gynecological Society. Dr. Hendee has served as president in the Atlanta Obstetrical and Gynecological Society, the Dan Thompson Obstetric and Gynecologic Society, and the South Central Obstetrical and Gynecological Society.

Sixth District

Kenneth Alonso, M.D., F.A.C.P., pathologist at Henry General Hospital, presented a paper at the World Congress of Federation of Societies of Biology and Nuclear Medicine in Paris on localization of antibodies to estrogen receptors in experimental breast tumors and their implications for therapy.

John Thomas West, M.D., and **M. Julian Duttera, M.D.,** of LaGrange, attended the 13th International Cancer Conference held in Seattle, Washington, Sept. 8-13, 1982. An estimated 10,000 persons attended and over 4,000 original research papers were presented. Naturally, in such a large and diverse meeting, one might sometimes find oneself in the midst of a presentation which taxed one's ability to comprehend. Such an experience was Dr. West's when he attended a session detailing the latest work in the development and use of interferon in the treatment of cancer. He recounted his experience in the following verse:

THE WONDERS OF INTERFERON

Men of learning and occult facts
Tell of the wonders of hidden acts
And talk of myriad unproven actions
Of mighty, miniscule, mysterious fractions.

With complex slides, and tiny script
They tell of theories, and often quip
That though they can hardly prove their stand
The un-proof is beyond all mortal man.

And so go the hours of dark speculation
Midst slumping bodies, and spent cerebration
Till at last the crowd oozes out of the room
To the ignorant light of the bright afternoon.

Ninth District

H. Fred Gober, M.D., of Gainesville, is now a fellow of the American College of Obstetricians and Gynecologists. Dr. Gober became a diplomate of the American Board of OB-GYN last November, at which time he began meeting criteria for a fellowship.

Jasper physician, **Guerrant H. Perrow, M.D.,** has been named the recipient of the 1982 Appalachian Georgia Health Service Award. The award is given annually by the health systems agency to the volunteer or professional in the Appalachian Georgia region who has contributed most significantly to the health care of area residents.

Tenth District

Carol Graham Pryor, M.D., Augusta obstetrician and gynecologist, is the 1982 recipient of the Georgia College Alumni Achievement Award. Dr. Pryor was the first woman in Georgia to be certified by the American Board of Obstetrics and Gynecology and was the first woman to become a member of the Georgia Chapter of the American College of Surgeons. She has twice served as chief of staff in obstetrics and gynecology at St. Joseph's Hospital and was a founding doctor of Doctors Hospital. She was Medical Woman of the Year in 1961.



Dr. James Kaufmann, of Atlanta, Chairman of MAG's Legislative Committee (right), and Stephen Davis, of MAG staff, were among those arriving from Atlanta by helicopter at Bibb County Medical Society's annual barbeque picnic in Macon. The helicopter, piloted by Captain Larry Self, was provided by Metro Ambulance in Atlanta.

SOCIETIES

The **Bibb County Medical Society** held its Annual Picnic, September 28, 1982, at Walthall's Lake, Thomaston Road in Macon. The event was attended by approximately 250 members and their wives and numerous local politicians, which included Dr. and Mrs. J. Roy Rowland, of Dublin.

The highlight of the evening was the arrival by helicopter of Dr. Jim Kaufmann, MAG Legislative Committee chairman, and Stephen Davis, Gould Hagler, Jr., and Susan J. Dillon, of the MAG staff. The helicopter was furnished by Metro Ambulance of Atlanta. Everyone can verify Captain Larry Self's capable abilities as pilot as he circled the picnic area twice and then set the helicopter down on one corner of the parking lot.

The **Medical Association of Atlanta** and the **MAG** are sponsoring a medical seminar series, Jamaican Adventure, by INTRAV. The seminar carries AMA category 1 credit. For further information, contact Eleanor Somerville at MAA, Ph: 404-874-2714.

John F. Kiser, Executive Director of the **Medical Association of Atlanta,** has been elected a director of the American Association of Medical Society Executives.

The annual barbeque of the **Muscogee County Medical Society** was held September 9, at the Green Island Country Club in Columbus. This event welcomes new physicians who have entered the community since the previous year. Local legislators also traditionally attend.



Attending the annual barbeque in Columbus are, left to right, Representative George Hooks and his wife, Gail, from Americus, and Dr. Jimmy Sullivan, MAG's Treasurer, and his wife, Bunny, from Columbus.



The Muscogee County Medical Society hosted its annual barbeque in Columbus in September. Dr. John D. Watson, Jr., is pictured in the center.

Board of Directors Highlights — *(Continued from page 809)*

MAG Mutual Insurance Company — Dr. Hollis gave a (glowing) status report of MAG Mutual Insurance Company's activities up to the present. There have been 1801 Surplus Certificates sold; 667 applications for insurance received; 515 insurance policies written; 7 applications rejected by the Underwriting Committee; $2,452,706 annual premiums written; and $4,600,000, plus, in assets. A national investment advisory firm, Scudder, Stevens, and Clark, of Boston, has been employed to invest funds and manage the portfolio. All investments are fixed income securities. The average maturity of the investments is 1.7 years, and the average yield is 12.2%. Reinsurance contracts have been drawn with Lloyd's of London. MAG Mutual will retain $100,000 of risk for each individual and $200,000 for each claim. MAG Mutual has 14 people on its staff.

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Committee Activities . . .

Executive Committee Highlights — September 17, 1982

Disabled Doctors Committee — Dr. Edward Waits, Chairman of this committee, requested to change the name of the Disabled Doctors Committee to the Impaired Physician Committee; the Executive Committee approved.

Dr. Waits discussed an Advocacy Program that would have an interested physician from a hospital, local medical society, or a specialty society serve in his local area as an advocate for any physician impaired because of chemical dependency. This physician would encourage impaired physicians to participate in our program and then follow up his care after he was treated, released and back into his area in practice. The Executive Committee approved this program.

The American Psychiatric Association and Roehrig Pharmaceuticals awarded a $10,000 Fellowship Grant to the consortium of impaired professional programs at Ridgeview Institute, of which MAG Impaired Physician Committee is a member. The grant will be presented to Emory University School of Medicine for a fellowship in addictology.

Physician/Lawyer Liaison Committee — Dr. Lil James, Chairman of MAG Physician/Lawyer Liaison Committee, informed the Executive Committee she would have no trouble working with the President and General Counsel of the State Bar Association insofar as revising the principles governing physician/lawyer relationships. A new set of guidelines or principles are being drawn up and will be presented to the MAG Board of Directors in January.

Risk Management Committee — Dr. J. Rhodes Haverty, Chairman of this committee, recommended that the Executive Committee review its regulations for future Risk Management Seminars and that MAG Mutual be a co-participant with the St. Paul Co. in future seminars. The Executive Committee so moved.

Medical Practice Committee — This Committee is developing an educational brochure about HMOs in which both pro and con facts are presented. It is for public distribution in areas where HMOs exist or are being developed. The Executive Committee deferred this matter to the Board of Directors for their consideration, suggesting that legal counsel review the brochure and make any necessary changes.

FTC Washington Visit — Drs. Charles Hollis and Joe Nettles, and Messrs. Jim Moffett and Rusty Kidd went to Washington relative to FTC Legislation (the Luken-Lee Amendment and the Broyhill substitute). MAG opposes the Broyhill amendment, since it is not a compromise but would strengthen the FTC. Dr. Hollis reported that they may have the support of eight out of ten Georgia congressmen.

The November, 1982, Executive Committee Meeting was changed to meet on Friday, November 12, at 5:00 p.m. at Callaway Gardens.

Highlights — Board of Directors Meeting — September 18, 1982

Auxiliary Report — Mrs. Barbara Thibodeaux, President of the MAG Auxiliary, reported on the Auxiliary activities this year. The Auxiliary is participating in the installation of Mrs. Glenda Bates, of Cuthbert, as the AMA Auxiliary President in 1983.

MAG Delegation to AMA Meeting — In order to assure full representation at the AMA House of Delegates, the Board adopted a policy to provide that if those members who regularly attend AMA House of Delegates meetings should not be able to do so, then others from the Executive Committee would be asked to attend in their place, on a rotating basis, thereby requiring no additional monies other than those already contained in the budget adopted by the MAG House of Delegates.

CHAMPUS Bid — The request that MAG endorse the CHAMPUS bid by California/Georgia Blue Cross/Blue Shield was not adopted.

MAG Leadership Conference — The Board agreed to authorize funds from its Contingency Fund in the amount of $7,750 for the MAG Leadership Conference to be held in November at Callaway Gardens.

Organization of Hospital Medical Staffs — Dr. Hollis reported that MAG is in the process of organizing a Hospital Medical Staff Section. The MAG Leadership Conference will afford this group an opportunity to meet and to discuss and identify issues unique to hospital medical staffs. The MAG Steering Committee for the hospital medical staffs has drawn up Bylaws which will be presented at the Friday meeting of the Leadership Conference. It was pointed out that when the AMA is ready, the Hospital Medical Staff Section will be ready to participate. Dr. Hollis requested that if anyone had any ideas or views on how MAG might effect the organization of a Hospital Medical Staff Section, please contact him or Mr. Moffett.

MAG Audit — Mr. Lamar Bount, of Hyatt, Imler, Ott, and Blount, P.C., presented the MAG Audit covering the period June 1, 1981, through August 31, 1982, a copy of which is on file at the MAG Headquarters. Mr. Blount found no irregularities, and the Board accepted the Audit as presented.

Medicine/Business Coalition Funds — The House of Delegates directed that the MAG support a Statewide Coalition. On June 5, the Board authorized MAG to join the Greater Atlanta Coalition. The Executive Committee, on August 21, voted to become a sustaining member of the Greater Atlanta Coalition on Health Care, acting on the recommendation of the MAG Cost Awareness Committee.

The following motions were acted upon:

1. Authorized the MAG to become a sustaining member of the Coalition and allocated $4,000 from the Contingency Fund for this purpose, subject to a formal invitation to join the Coalition;

2. That the MAG request the Coalition to authorize sustaining memberships in the Coalition for those county medical societies in the general area of the Coalition; and

3. Further funding of this project be brought back to the September, 1983, Board for evaluation, and that

4. Any commitment MAG makes to participate in the Greater Atlanta Coalition be available to other county medical societies on a pro rata basis, not to exceed the amount voted for the Greater Atlanta Coalition.

Retainer vs Fee for Services — The Board voted to continue to retain legal counsel on a fee for service basis rather than on a retainer.

MAG Mutual Payment — The Board received $61,800 from MAG Mutual Insurance Company as the first payment on its debt to the Association.

MAG Annual Session for 1984 — After lengthy discussion, the Board agreed to hold this Session at the Monarch Plaza, Atlanta, on April 25-29, 1984, a move from the previous Jekyll Island location.

MAG Mutual Space Request — The MAG Mutual Insurance Company is growing rapidly and will need more space (approximately 6000 square feet) in the foreseeable future. The Board referred this matter to the Building and Land Committee to study and evaluate additions and to study the cost factors.

Medical Practice Committee — The Board adopted the report from Dr. Dan Jordan and the Medical Practice Committee recommending that the public needed to know the pros and cons of HMOs, both those existing and those contemplated. A total of $3020 was allocated for brochures, subject to legal counsel's review; $2000 to $3000 was allocated as needed to publish this brochure in the Atlanta newspapers.

Nursing Committee — The Board heard Dr. John P. Wilson, Chairman of the Nursing Committee, recommend that the Nurse Practice Act be completely rewritten based on the Committee's review of specific areas containing problems. The Board aproved legal counsel working with the Committee, fiscal note, $4,000 and more if needed, to develop the appropriate language to assure that the Nurse Practice Act does not infringe on the practice of medicine. The Board empowered the Executive Commitee to approve the additional funds as needed. The Board also approved reactivating the Joint Practice Committee between the MAG and the Georgia Nurses Association.

The Board empowered Dr. Wilson, as Chairman of the Nursing Committee, to express MAG's concerns regarding the clinical experience of nurses to the Board of Nursing and to inform appropriate authorities that MAG policy is to add a Third Clinical Year to the Two-Year Community College Nursing Program. This year would consist of about 6 hours a day of actual work in the hospital, for which the nursing student would be paid, and 2 hours a day of didactic instruction. At the end of the second year, a GN Degree would be awarded, and at the end of the third year, the RN Degree would be awarded. The Board urged that both the Legislative and Nursing Committees work with legal counsel to effect the Nurse Practice Act.

(Continued on page 807)

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Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.[1] In a double-blind crossover study of 42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.[2] This difference was highly significant ($p<0.001$). And a retrospective study of 254 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.[3]

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturn awakenings.[4] The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.[5-8] Since the risk of oversedation, dizziness, confu

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sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.[1] Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.[9,10] However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.[11] When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: **1.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **4.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Meyer JA, Kurland KZ: *Milit Med 138*:471-474, Aug 1973. **6.** Feffer HL, Gibbons B: *Med Times 101*(8):130-135, Aug 1973. **7.** Jacobson A *et al*: *Psychophysiology 7*:345, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 1978. **10.** Kales A *et al*: *JAMA 241*:1692-1695, Apr 1979. **11.** Monti JM: *Methods Find Exp Clin Pharmacol 3*(5):303-326, 1981.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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MAG Audited Financial Statement, 1981 and 1982

MAG Board of Directors
Atlanta, Georgia

We have examined the balance sheets of the Medical Association of Georgia as of May 31, 1982 and 1981, and the related statements of revenues, expenses and changes in fund balance and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of the Medical Association of Georgia at May 31, 1982 and 1981, and the results of its operations and the changes in its financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Hyatt, Imler, Ott & Blount, P.C.
Certified Public Accountants
Atlanta
August 27, 1982

Balance Sheets
Medical Association of Georgia

	Year Ended May 31	
	1982	*1981*
ASSETS		
Current Assets		
Cash and commercial paper — Notes E and F		
Demand deposits	$ 55,658	$ 30,583
Savings deposits	100,260	270,500
Commercial paper	1,016,104	1,194,631
	1,172,022	1,495,714
Prepaid expenses	10,326	13,597
Accounts Receivable		
Receivable for program contracts	15,776	26,090
Advertising	5,234	4,650
	21,010	30,740
Total Current Assets	1,203,358	1,540,051
Other Assets		
Due from sale of subsidiary — Note D	9,787	19,118
Investments — Note F	5,365	3,790
Total Other Assets	15,152	22,908
Property and Equipment — Note B		
Land	80,000	80,000
Buildings	876,549	757,489
Furniture and equipment	305,470	213,792
	1,262,019	1,051,281
Less allowances for depreciation	(415,629)	(338,985)
	846,390	712,296
Construction in progress	-0-	37,796
Total Property and Equipment	846,390	750,092
	$2,064,900	$2,313,051

	Year Ended May 31	
	1982	*1981*
LIABILITIES AND FUND BALANCE		
Current Liabilities		
Accounts payable	93,015	$ 113,569
Advance collections	2,871	4,378
Other current liabilities	11,148	-0-
Current maturities of long-term debt — Note B	47,264	43,859
Total Current Liabilities	154,298	161,806
Other Liabilities		
Restricted contributions — Note E	-0-	59,139
Restricted funds — Note F	38,327	27,737
Retirement and deferred compensation liabilities	30,246	25,124
Total Other Liabilities	68,573	112,000
Long-Term Debt — Note B	70,520	117,784
General Fund Balance		
Designated for specific purposes		
Regular operations	30,000	30,000
Building operations	66,275	275,744
Lecture expenses	1,658	1,388
	97,933	307,132
Undesignated	1,673,576	1,614,329
Total Fund Balances	1,771,509	1,921,461
	$2,064,900	$2,313,051

See notes to financial statements.

Statements of Changes in Fund Balances

	Designated for Specific Purposes				
	Operations	*Building*	*Lecture*	*Undesignated*	*Total*
Balance at May 31, 1980	$30,000	$208,227	$1,688	$1,540,444	$1,780,359
Adjustment of beginning fund balance	-0-	13,804	-0-	(50)	13,754
Excess (deficiency) of revenues over expenses	-0-	-0-	-0-	127,648	127,648
Fund transfers	-0-	53,713	-0-	(53,713)	-0-
Disbursements	-0-	-0-	(300)	-0-	(300)
Balance at May 31, 1981	30,000	275,744	1,388	1,614,329	1,921,461
Excess (deficiency) of revenues over expenses	-0-	-0-	270	(96,509)	96,239
Fund transfers	-0-	(155,756)	-0-	155,756	-0-
Disbursements	-0-	(53,713)	-0-	-0-	(53,713)
Balance at May 31, 1982	$30,000	$66,275	$1,658	$1,673,576	$1,771,509

See notes to financial statements.

Statements of Revenues and Expenses

	Year Ended May 31	
	1982	*1981*
Revenues		
Operating revenues		
Membership dues	$ 971,783	$ 966,800
Advertising	102,953	72,439
Specialty society	37,839	30,000
Seminars	7,348	11,289
Other	5,602	8,011
	1,125,525	1,088,539
Data processing fees	234,971	183,766
Interest income	173,818	152,365
Rent income	5,663	38,644
Other	21,433	38,428
Total Revenues	1,561,410	1,501,742
Expenses		
Salaries	568,163	508,366
Employee benefits	98,518	64,004
Pension plan	37,784	42,451
Depreciation	78,925	48,780
Interest expense	10,636	12,531
Legal fees	85,344	59,169
Equipment rent	10,680	22,058
Contributions — Note E	159,849	25,629
Other expenses		
Committees	187,900	189,253
Membership services	139,464	120,497
Journal	75,697	70,535
Data processing	73,132	62,948
Building expenses	83,140	67,525
Other	48,687	80,348
Total Expenses	1,657,919	1,374,094
Excess (Deficiency) of Revenues Over Expenses	$ (96,509)	$ 127,648

See notes to financial statements.

Notes to Financial Statements
Medical Association of Georgia

Note A — Summary of Significant Accounting Policies

The significant accounting policies adopted by the Medical Association of Georgia are set forth below.

Revenue: Revenue attributable to dues from Association members are recognized as income as the funds are received by the Association. The effect of this policy, as compared to recognizing dues on an accrual basis, is immaterial. All other revenue and expense items are recognized on the accrual basis.

Income Taxes: The Association is exempt from Federal income taxes under the provisions of the Internal Revenue Code, Section 501(c)(6).

Property and Depreciation: Property and equipment is stated at cost, and includes expenditures for new facilities and improvements to existing facilities. Expenditures for normal maintenance and repairs are charged to operations as incurred. Depreciation is computed on the straight-line method over the expected useful life of the assets.

Commercial Paper: These investments generally consist of 30-day bank holding company notes and are carried at cost, which approximates market value.

Note B — Long-Term Debt

The Association is obligated under a 7.5% mortgage note payable $4,541 monthly (including principal and interest) until 1984. The land and building have been pledged as collateral for the loan.

Note C — Retirement Plan

The Association has a non-contributory, defined benefit retirement plan for all employees age 22 and over with one year or more of service. There is no past service cost related to the plan, and it is the Association's policy to fund all costs as accrued. The plan's asset value is in excess of the present value of vested benefits.

Note D — Sale of Subsidiary and Note Receivable

During 1981 the Association sold its investment in MAG Services, Inc. to a member of the Association for $7,500 and a $22,500 note. The note bears interest of 10% per year and

Statements of Changes in Financial Position

	Year Ended May 31	
	1982	*1981*
Sources of Working Capital		
Excess (deficiency) of revenues over expenses	$ (96,509)	$ 127,648
Add expenses not requiring outlay of working capital during the period		
Provision for depreciation	78,925	48,780
Total From Operations	(17,584)	176,428
Restricted contributions received	3,800	103,803
Decrease in other assets	7,756	2,717
Increase in other liabilities	15,710	52,861
Adjustment to beginning fund balance	-0-	13,854
Increase in lecture fund	270	-0-
Total Sources	9,952	349,663
Uses of Working Capital		
Net additions to property and equipment	175,221	72,147
Reduction in long-term debt	47,264	43,859
Expenditure of restricted contributions	62,939	44,664
Disbursement from lectureship fund	-0-	300
Disbursement from building fund	53,713	-0-
Total Uses	339,137	160,970
Increase (Decrease) in Working Capital	(329,185)	188,693
Working capital at beginning of year	1,378,245	1,189,552
Working Capital at End of Year	$1,049,060	$1,378,245
Increase (Decrease) in Working Capital By Components		
Demand deposits	$ 25,075	$ (157,735)
Savings deposits	(170,240)	255,233
Commercial paper	(178,527)	192,276
Prepaid expenses	(3,271)	13,597
Accounts receivable	(9,730)	(52,387)
Accounts payable	20,554	(53,574)
Advance collections	1,507	(2,281)
Other current liabilities	11,148	-0-
Current maturities of long-term debt	3,405	(6,436)
Increase (Decrease) in Working Capital	$(329,185)	$188,693

See notes to financial statements.

matures in 1983. Under the agreement, a minimum of $7,500 principal is to be paid each year and payments of principal and interest are made by the Association withholding 40% and 15%, respectively, from payments to the purchaser for printing services. Purchases of printing services from the firm owned by a member of the Association amounted to $18,000 in 1982.

Note E — Contributions

During 1981 the Association began efforts to establish a physician owned, mutual liability insurance company. Contributions were received from interested physicians and these funds were expended for the designated purpose of establishing the insurance company. As of May 31, 1981, $59,139 of the restricted contributions had not yet been expended. Additionally, the Association has incurred $25,629 of expenses in 1981 and $159,849 in 1982, exclusive of interest, for the insurance company's benefit. Recovery of a portion or all of these expenses from the insurance company is possible; however, due to the uncertainty of the recovery, these expenditures have been charged to operations as contribution expense.

Note F — Restricted Funds

The Abner W. Calhoun Lectureship Fund and the Crawford W. Long Memorial Fund are restricted for specific purposes. Income is provided by donations, interest and dividends, which is added to the fund balances. Expenditures are made for the specified purposes, with Board approval, and charged against the fund balances. The respective fund balances were:

	1982	*1981*
Abner W. Calhoun Lectureship Fund	$ 3,790	$ 3,790
Crawford W. Long Memorial Fund	34,537	23,947
	$38,327	$27,737

The assets of the Abner W. Calhoun Lectureship Fund are investments, carried at cost and their market value is $2,592 at May 31, 1982, and $2,418 at May 31, 1981. The assets of the Crawford W. Long Memorial Fund consist of cash.

Note G — Contingency

The Federal Trade Commission has alleged that the Association violated certain federal regulations. Management of the Association believes these charges are without merit and legal counsel is vigorously contesting them. Due to the uncertainty as to the outcome of this action, no provision for the effects, if any, of settlement of this action has been made in the accompanying financial statements.

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TEGA-TUSSIN: Provides phenylephrine HCL, an effective respiratory mucosal, pulmonary decongestant, mild bronchodilator and vaso-pressor.

DOSAGE: Adults - One teaspoonfull every 3 to 4 hours. Children over 6 years - ½ Adult dose. Not recommended for children under 6 without very close supervision by physician.

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MORE DETAILED INFORMATION AVAILABLE ON REQUEST

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTH-EAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PRODUCTS ARE DESIGNED WITH THE FAMILY PHYSICIAN IN MIND

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Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socio-economic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]



Before prescribing, please consult complete product information, a summary of which follows:
Each Bcrocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.
Contraindications: Hypersensitivity to any component.
Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
Adverse Reactions: Adverse reactions have been reported with specific vitamins and

ROCHE

,000,000 hospital patients with nfections.[4] Many are anoectic and may have a markedly educed food intake. Supplements re often provided as a prudent ieasure because the vitamin staus of critically ill patients cannot e readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]



Berocca Plus
A balanced formula for prophylactic or therapeutic nutritional supplementation.

Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

Berocca Plus,
highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

erals, but generally at levels substanly higher than those in Berocca Plus. wever, allergic and idiosyncratic reacns are possible at lower levels. Iron, n at the usual recommended levels, been associated with gastrointestinal lerance in some patients.

age and Administration: Usual adult age: one tablet daily. Not recomnded for children. Available on preption only.

w Supplied: Golden yellow, capsuleped tablets—bottles of 100.

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When mild to moderate pain is a side effect of "Fitness"

RUFEN®
(ibuprofen)

measures up... at a reasonable cost!

A Single-Entity Pain Reliever As-Good-As or Better-Than Codeine Combinations

"...particularly effective in soft tissue disorders including sports injuries,"[1] Rufen stops pain at the site of injury and inflammation, not at the level of central perception. There is no dulled sensorium, no special need for warnings about driving or cautions about use of machinery. Your patient gets fast, effective pain relief...potent anti-inflammatory action...excellent tolerance...*plus* the exceptional economy that only Rufen offers. Next time one of your patients asks for pain relief, let Rufen show you how it measures up.

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Shreveport, LA 71106
Pioneers in medicine for the family

See next page for brief summary of prescribing information.

Measure RUFEN® (ibuprofen) against "standard" mild to moderate pain

Dental pain and episiotomy pain are predictable, reproducible "standards" that make possible objective comparisons of effectiveness of different analgesic agents.

- Measured against 15, 30 and 60 mg doses of codeine phosphate in a double-blind study of 287 patients, 400-mg doses of ibuprofen proved "significantly better than codeine on almost all pain intensity, degree of relief and duration of analgesia parameters."[2]
- Measured against a propoxyphene-acetaminophen combination for pain relief after 3rd molar extractions, ibuprofen proved equally effective and caused fewer side effects. Ibuprofen was associated with faster recovery, evidenced by more rapid reduction of trismus and return to normal function.[3]
- Measured against post-episiotomy pain in 30 patients, "ibuprofen was effective in treating the swelling as well as pain...during the first and worst days. Therefore, it is not only the analgesic but also the anti-inflammatory effect of ibuprofen that are the beneficial factors..."[4]

Measure RUFEN® (ibuprofen) against any mild to moderate pain

RUFEN	Acetaminophen + codeine combinations
• single-entity, peripheral-acting analgesia	• combined drugs act partly through central opioid pathways
• powerful treatment of both pain and inflammation	• virtually no treatment of the inflammatory component
• better tolerated than aspirin	• combined side effects of two drugs—warning required about driving or operating machinery; possible respiratory depression with alcohol, tranquilizers, other common medications
• no narcotic risk, red tape, records	• narcotic precautions required
• matchless economy in a modern NSAID	



References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases, 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: Canad Dent Assoc J 46:433-439, 1980.
3. Selwyn P and Giles AD: Br Jrl of Clin Practice, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgesic. Pg 87-90. 1980.
4. Taina E: Curr Med Res Opinion, 7:423-428, 1981.

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And Rufen® Measures Up Best

RUFEN® (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). Central Nervous System: dizziness*, headache, nervousness. Dermatologic: rash* (including maculopapular type), pruritus. Special Senses: tinnitus. Metabolic: decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. Central Nervous System: depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. Dermatologic: vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. *Special Senses:* hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) [see PRECAUTIONS]. Hematologic: neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. Cardiovascular: congestive heart failure in patients with marginal cardiac function, elevated blood pressure. Allergic: syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). Renal: acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. Miscellaneous: dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. Central Nervous System: paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. Dermatologic: toxic epidermal necrolysis, photoallergic skin reactions. Special Senses: conjunctivitis, diplopia, optic neuritis. Hematologic: bleeding episodes. Allergic: serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis. Endocrine: gynecomastia, hypoglycemia. Cardiovascular: arrhythmias (sinus tachycardia, bradycardia, and palpitations). Renal: renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

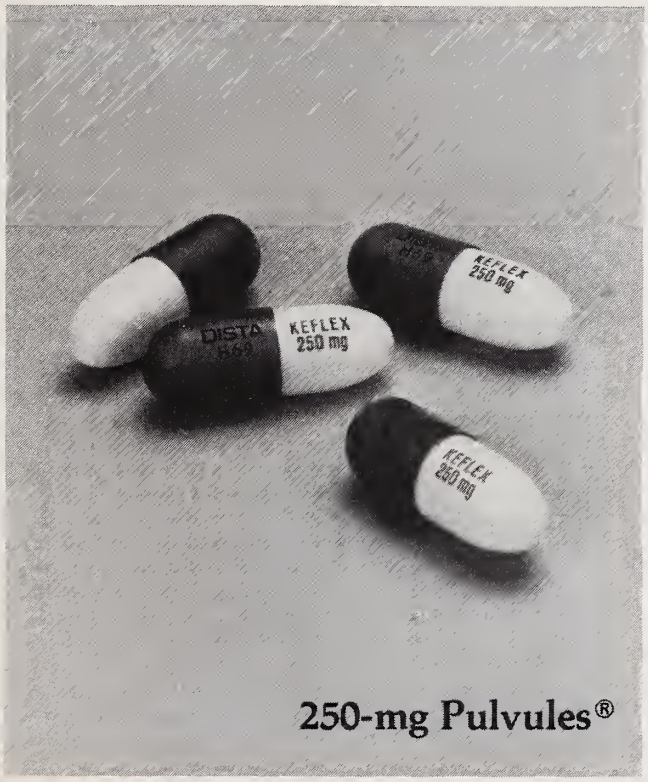
DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. *Do not exceed 2,400 mg per day.*

CAUTION: Federal law prohibits dispensing without prescription.

easy to take



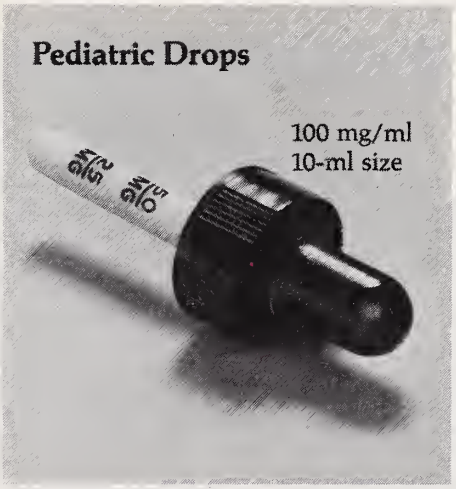
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Peachford Hospital.

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Such problems as alcoholism, drug addiction, adult, adolescent and child psychiatric troubles are discussed in this free brochure. It explains, in depth, Peachford Hospital's uniquely positive, comprehensive program of recovery... that's working!

Peachford is a full-service 204-bed psychiatric hospital, providing short, intermediate and long-term treatment programs for adults, children and adolescents. Hospital care is available to all patients regardless of the severity of their illness or of complicating addictions or medical problems.

Programs

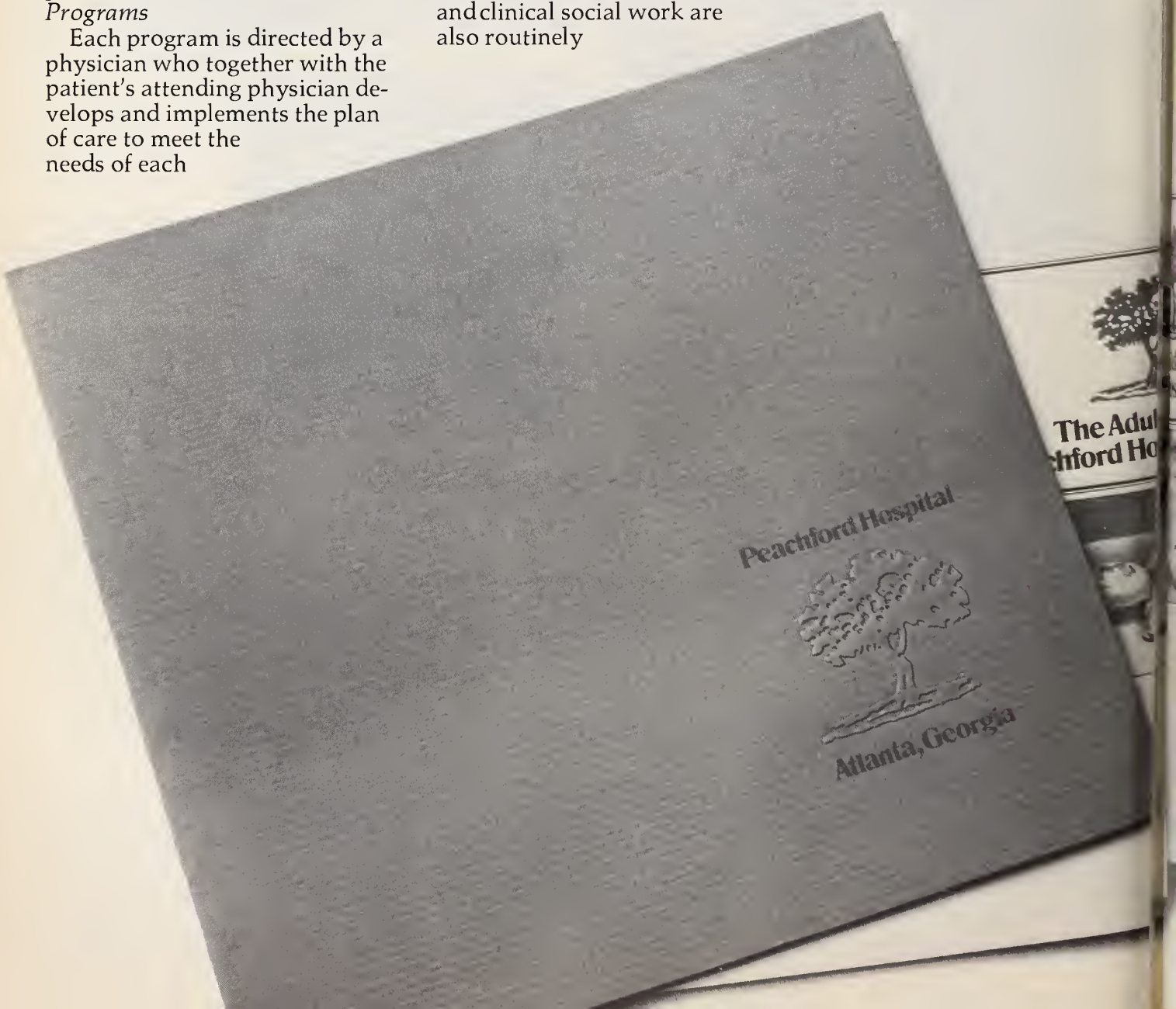
Each program is directed by a physician who together with the patient's attending physician develops and implements the plan of care to meet the needs of each patient on an individualized basis.

Adult Psychiatric Program — provides a structured therapeutic milieu approach with multiple teams of up to 13 patients each for individuals 18 years of age and older. Individual and group therapies are conducted daily, with activities therapy and clinical social work services scheduled throughout the week.

Young Adult Program — a unique, innovative program specifically designed for the young adult patients ages 18-25. Therapy on a group as well as an individual basis is provided daily. Activities therapy and clinical social work are also routinely conducted throughout the week.

Adolescent Psychiatric Progra consists of treatment units of 16 patients each between the ages c and 17. All adolescent patients p ticipate in individual, family, an group therapy sessions, some da and some scheduled throughout week. Educational needs are me an individualized basis in an org ized classroom setting. Parents the patients meet together week in group sessions to discuss common issues and concerns.

Child Psychiatric Program — designed as a 12 patient unit and



rious problems.

rovides individualized services for ildren between the ages of 4 and . The structured daily program r all children includes individual d group therapy sessions, as well individualized programs for edu- tion, activities therapy, develop- ental play, and social services. t, dance, music, occupational, d recreation therapy are vital mponents of the program. rents are involved in family sessions and parents' groups.

Addictive Disease Program — includes detoxification, intermediate care, and aftercare services based on the philosophy of Alcoholics Anonymous. The treatment program is designed to focus on the total person through participation in educational lectures, group therapy, activities therapy, and family programs. The goal of the program is to teach the addicted individual a manner of living by which he or she may remain free of all addictive substances.

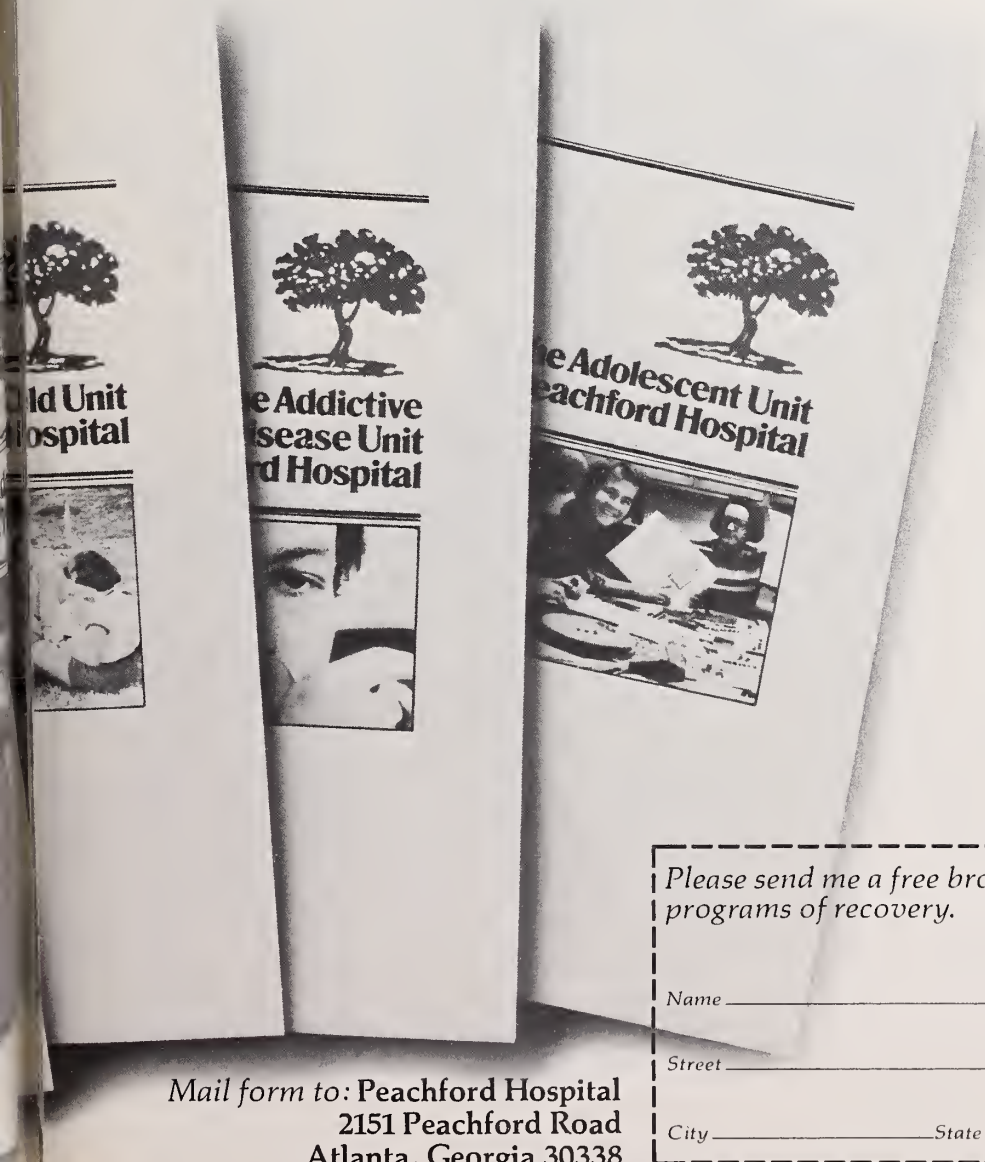
The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, art therapists, music therapists, dance therapists, teachers and counselors.

Physical Facilities — located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an x-ray department, a laboratory, emergency treatment rooms, auditorium, gymnasium, adolescent and children's schools, group therapy rooms, activities therapy rooms, year-round swimming pool, tennis courts, and athletic field for softball, football, volleyball, basketball and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

For your free brochure, or for a personal tour of the facilities and an explanation of the programs, please contact Peachford Hospital at (404) 455-3200, or use the order blank below.



Please send me a free brochure about Peachford Hospital's programs of recovery.

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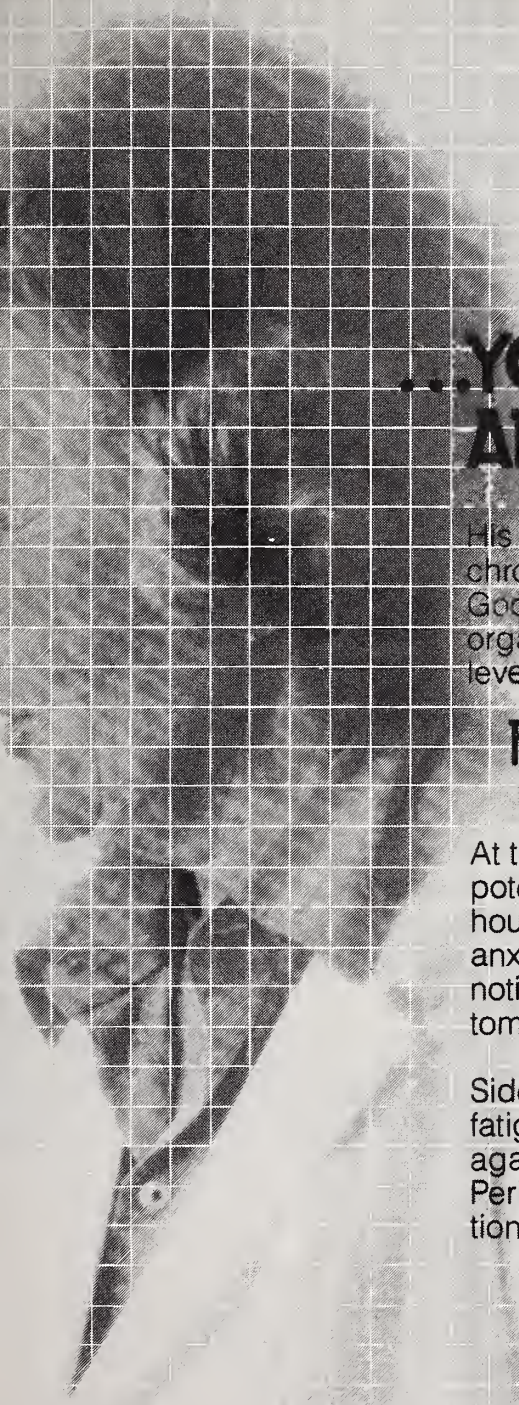
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THE PATIENT THINKS HE HAS HEART TROUBLE...





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

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Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701
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Everyone has an excuse for not seeing their doctor about colorectal cancer. However, every year 52,000 men and women die of colorectal cancer in this country alone. Two out of three of these people might be saved by early detection and treatment. Two out of three.

So what is your excuse? Today you have a new, simple, practical way of providing your doctor with a stool specimen on which he can perform the guaiac test. This can detect signs of colorectal cancer in its early stages before symptoms appear. While two out of three people can be saved. Ask your doctor about a guaiac test, and stop excusing your life away.

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More than 90% of breast cancers can be detected with the use of a simple, easy-to-use device called the [illegible]

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Atlanta Area — Emergency Medicine: Full-time staff and Associate Director practices available in modern, well-equipped emergency department. Patient volume of 28,000 ensures professional stimulation. Excellent guaranteed income plus fee-for-service bonus provides financial security plus additional income potential. Paid professional liability insurance, equitable scheduling, compensation for administrative responsibilities, plus additional benefits provided. For complete details, call Tom Baldwin toll-free 1-800-325-3982, or write: P.O. Box 27352, St. Louis, MO 63141.

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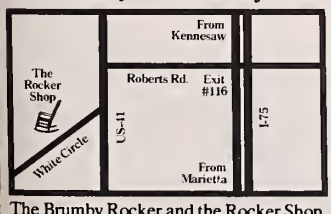
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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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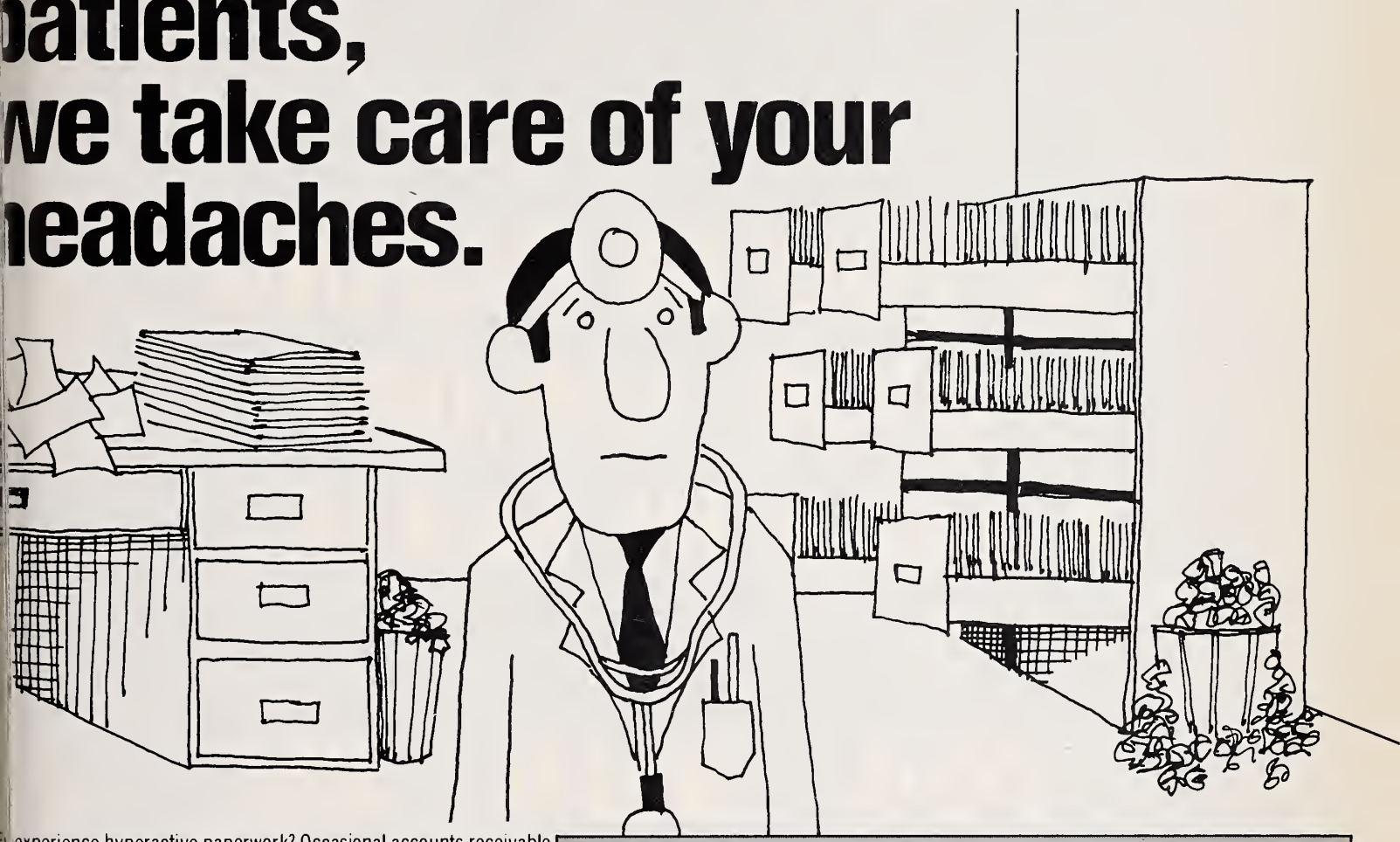
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Letters to the Editor . . .

The Georgia Special Olympics Needs Physicians

Dear Fellow Physicians:

One of the most successful programs to come to our state in years is the Georgia Special Olympics. It has offered services to many youngsters who would never have had the opportunity to reach their athletic potential; but more importantly, it has offered a social experience to these persons.

Almost everyone benefits from the activities of the Special Olympics. Not only do the athletes have social and athletic opportunities but also the volunteers who work with them have the opportunity to learn more about the problems encountered by retarded persons. The community as well is made aware of the needs of these individuals.

Like all athletic events, it is important to make sure that the participating individuals are physically fit for the events they will enter. This is where the help of the physicians of Georgia is important.

All athletes are required to have a physical exam prior to participating in the events. Before they can try out in their local areas for the Olympics, each must undergo a physical examination to insure that he or she is physically fit for competition. In the past, when these numbers were small, this did not present a particular problem. However, now that thousands of individuals are entering the program, it is becoming more difficult to have all of them examined by medical personnel. It is believed by many that this initial exam should be performed by a physician to insure that the individual is physically fit for competition.

My plea is for more Georgia physicians to become involved in the Special Olympics. We need physicians participating in the physical examinations as well as in the events themselves. It is an extremely gratifying experience to take part in such a valuable program. I would encourage the physicians of Georgia to seek out the Special Olympics program in your areas and offer your services in these physical examinations. I also would encourage Georgia physicians to become more involved with the program, as it is a most rewarding experience.

This past year in Warner Robbins, Georgia, there were more than 1200 athletes participating in the Spring games. These athletes represented only a small percentage of the total who had competed at the local level to win the honor of coming to the State games. All of the participants did their best and had a good time, equaled only by the satisfaction the volunteers derived from this experience. Tears and laughter mix well at the Olympics. Take it from one who has gained more than he has given, the Special Olympics is indeed a special experience.

For more information contact the state office at 1655 Tullie Circle, N.E., Atlanta, 30329, (404) 636-0388; or contact your local group.

Sincerely,
Thomas L. Tidmore, Jr., M.D.
Vice Chairman
Georgia Special Olympics

More on Hospice

Dear Sir:

In the interval between the writing and publishing of my recent paper in the *Journal* (''Hospice Care — An Alternative,'' October, 1982, pp. 693-5), a development on the national scene has occurred which will greatly assist in providing hospice care to our patients.

Section 122 of the Tax Equity and Fiscal Responsibility Act of 1982, passed and signed into law by the President, provides for the extension of Medicare benefits for a test period of 3 years to otherwise eligible persons who are terminally ill. The 3-year period will begin on November 1, 1983. The Secretary of DHHS will draft hospice standards and conditions of participation by September 1983.

This legislation will make hospice programs eligible for Federal Medicare benefits for the types of services described in the October article. If the 3-year period confirms that hospice care for the terminally ill is indeed more cost effective, the benefits will most likely be extended indefinitely.

The legislation has many provisions; some of the more significant are as follows:

1. Hospices will be recognized as distinct providers and will not need separate licensure or certification as home health, hospital, or nursing agencies.
2. A total benefit period of 210 days in two 90- and one 30-day block is possible.
3. A person could change his mind about hospice and return to traditional care at any time.
4. The patient's private attending physician could continue to bill Medicare as usual under this bill.
5. The patient need not be home bound to receive services.
6. Comfort items are included as reimbursable.
7. Inpatient care restrictions relating to acute conditions are waived, allowing chronic and terminal care admissions.
8. Patient *and* family are considered the unit of care, allowing counseling and family services.
9. With minimal limitations, homemaker services, supplies, equipment, and drugs are paid by Medicare.
10. Direct costs of bereavement services — although required of all hospices — are not reimbursed.
11. The hospice care programs are to remain primarily home based, with inpatient care as a back up service.

Although the exact method whereby the hospice program will be recognized as eligible for reimbursement is not stated in the law, the Secretary of DHHS will determine a method of working with state agencies and others to determine eligibility prior to September, 1983. At the present time, the Joint Commission on Accreditation of Hospitals (JCAH) is working with the National Hospice Organization and others to promulgate a set of standards for hospice accreditation. Presumably, these standards and one or both of these agencies may be involved in the process of selection of hospices for participation in this new federal program.

Paul T. Werner, M.D.
Macon

Licensure of Physicians' Office Laboratories?

Dear Sir:

As you may be aware, last year a bill was introduced into the State Legislature which would have had the effect of requiring licensure of physicians' office laboratories. A joint group of laboratorians, Department of Human Resources offices, and physicians had consideration of this bill deferred.

MAG was asked to help the State study the problem of physician office laboratories and appointed Drs. Morris Brown, Stephen May, and Robert DeLashmutt to a joint subcommittee. You will be receiving the following letter from the subcommittee along with a brief survey:

Dear Doctor:

A bill was introduced into the last session of the Georgia General Assembly which proposed to regulate physician owned laboratories and require licensure of these laboratories. The bill as proposed would have repealed the portion of the Georgia Laboratory Licensure Law which allows the exemption from licensure of clinical laboratories operated by duly licensed physicians exclusively in connection with the diagnosis and treatment of their own patients. [Ref. Ga. L. 1970, p. 531, et seq. and *O.C.G. 31-22-9(4)].*

Because of the cost and broad implications which such a change would have had on medical office practices, the Laboratory Advisory Council and the Department of Human Resources recommended that no action be taken on the bill in its original form and that the Department of Human Resources enter into discussion with representatives of the medical profession to gain support for an alternative approach to laboratory improvement.

A committee consisting of representatives from the Laboratory Advisory Council, the Department of Human Resources and physicians practicing in the specialties of family practice, internal medicine and pathology was established and has reviewed the background of this issue, including the statute, the regulations, and existing data regarding current use of unlicensed office laboratories.

For the study to be complete, we need to update existing data with a repeat survey similar to one done seven years ago in 1975. For this survey a random sample of all licensed physicians in Georgia has been selected to receive this letter and the accompanying survey form. The needed information cannot be obtained without your help. Please assist us by filling out and returning the enclosed questionnaire so we can advise the Department and the Legislature on this important matter.

Sincerely yours,
Steven J. Steindel, Ph.D.
Chairman
Clinical Laboratory, Blood Banks and Tissue Bank Advisory Council

We urge you to respond rapidly, as MAG fully supports this approach.

Hans J. Peters, M.D.
J. G. Etheridge, M.D.
Members, Clinical Laboratory Council
November 1982

When your overweight patients seek your help with a weight reduction plan...

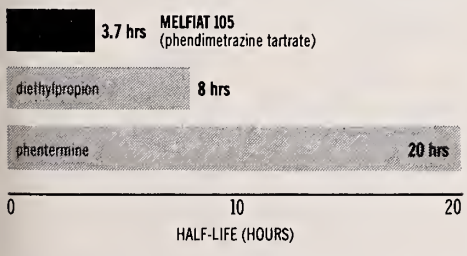


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Half-life comparison of MELFIAT 105 and other anorexiants[2]



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References: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine,* unclassified document ADAMHA, HHS. Office of Medical and Professional Affairs, NIDA, 1980.
2. Douglas JG, Munro JF: The role of drugs in the treatment of obesity, *Drugs* 21:362-373, 1981.

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WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.
Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
Allergic: Urticaria.
Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear sustained-release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.

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Incidental Intelligence . . .

Disciplinary Actions of Composite State Board of Medical Examiners

At the request of the Composite State Board of Medical Examiners (CSBME) (the "Board"), the Medical Association of Georgia has agreed to publish the results of disciplinary actions of the Board as a public service to physicians throughout the state.

The actions described below constitute those taken by the Board and are subject to appeal by the physicians involved to an appropriate superior court pursuant to the terms of the Georgia Administrative Procedure Act. The Board assumes responsibility for the accuracy of the information published in the Journal. *The following are actions taken between July 1, 1982, and September 30, 1982.*

WILMOTINE JACKSON, M.D. — Voluntary surrender of license effective July 15, 1982.

ROOSEVELT P. JACKSON, M.D. — Restoration of License effective July 15, 1982. Placed on probation for 3 years, commencing on the effective date of Order. Shall not apply for or possess a DEA registration. Shall not perform surgery of any kind. Shall complete and document 100 hours of CME approved by the Board in primary care prior to returning to practice. Shall permit the inspection of his office and hospital records by a representative of the Board no less than 4 times a year. In the event the Respondent leaves Georgia to reside or practice for periods longer than 30 days, he must notify the Board.

AGOSTINO CARLUCCI, M.D. — Emergency Suspension effective July 22, 1982. Imminent danger to the public health, safety, and welfare if the Respondent is permitted to continue to practice as a physician in the State of Georgia.

MARCELO R. SANTIAGO, M.D. — Consent Order effective August 11, 1982. Stayed revocation with probation. The Respondent shall be placed on probation for a period of 6 years, with conditions. Within 30 days from the effective date of Order, he shall surrender for cancellation his DEA registration with respect to Schedule II and II-N controlled substances for a period of 4 years. At the end of 4 years, he shall be eligible to petition the Board for reinstatement of his prescription writing privileges with respect to controlled substances in Schedules II and II-N. Within 30 days of Order, the Respondent shall submit to the Board for its approval a program in drug abuse education and/or pharmacology consisting of 50 hours, which the Respondent shall complete within 1 year from the effective date of this Order. He shall permit the inspection of his office and hospital records by a representative of the Board. Should the Respondent leave Georgia to reside or practice for periods longer than 30 days, Respondent shall notify the Board.

STANLEY GREGOROFF, M.D. — Consent Order effective August 11, 1982. Placed on probation for a period of 3 years, to be computed from February 18, 1982, with stipulations. Within 30 days from the effective date of Order, the Respondent shall submit to the Board for its approval a CME program in drug abuse and/or pharmacology, consisting of 28 hours, which the Respondent shall complete within 6 months of the effective date of this Order and provide documentation to the Board. He shall relinquish his DEA permit until February 18, 1983, or satisfactory completion of the approved course of CME described, whichever event shall first occur. Provided that the Respondent has otherwise complied with the terms of Order, the Respondent shall be eligible to apply for reinstatement of his prescription writing privileges with respect to controlled substances in Schedule III and upon proper petition of proof to the Board of his compliance with Order, the Board shall so reinstate the prescription writing privileges of Controlled Substances in Schedule III and all other necessary licenses, permits, forms, etc. necessary for the prescribing of the above described controlled substances in Schedules III, IV, and V. At the end of the second year of probationary period, February 18, 1984, the Respondent shall be eligible for the reinstatement of his privileges to prescribe Schedule II controlled substances. Shall permit the inspection of his office and hospital records by a representative of the Board. Should the Respondent leave Georgia to reside or practice for periods longer than 30 days, he shall notify the Board.

WILLIAM F. MCKEMIE, M.D. — License restored effective August 11, 1982. (Consent Order has been prepared with stipulations, however the Order has not been signed and returned to the Board by the Respondent. Will report on this case next quarter.)

HAROLD B. CARSON, M.D. — Consent Order effective October 1, 1982. License suspended until January 1, 1984. October 1, 1982, the Respondent shall submit to the Board for approval a program in drug abuse and/or pharmacology, consisting of 50 hours, which the Respondent shall complete by January 1, 1984. On or before October 1, 1982, Respondent shall surrender for cancellation his DEA permit. Until further order of the Board, the Respondent relinquishes his right to prescribe, administer, dispense, order, or possess controlled substances as defined by the Georgia Controlled Substance Act. By December 1, 1983, the Respondent shall submit evidence to the Board that he has undergone a complete physical examination within 2 months prior to that date. The Respondent's license shall not be restored if it appears that the Respondent is physically or mentally unable to resume the practice of medicine. Provided the Respondent shall otherwise abide by the terms of this Order, the Respondent shall be allowed to resume the practice of medicine on January 2, 1984 (subject to the restrictions outlined herein with respect to controlled drug substances), but the Respondent shall remain on probation for a period of 5 years commencing on said date, or for 5 years commencing on the date that the license is restored, with conditions of probation. Shall permit the inspection of his office and hospital records by a representative of the Board. Shall

submit annual reports regarding his physical and mental condition to the Board. In the event the Respondent leaves Georgia to reside or practice outside of Georgia, the Respondent shall notify the Board. The Board shall review and evaluate the practice of the Respondent at the end of the probationary period. After this evaluation, the Board shall have the right to extend or modify the terms of probation, if extension or modification is warranted by evidence presented to the Board. This Order shall serve as a public reprimand.

DAVID R. HOBBS, M.D. — Restoration of License effective September 9, 1982.

ANDREW A. DEKLE, M.D. — Interim Consent Order effective September 15, 1982. Agrees to voluntarily surrender for cancellation his DEA permit until further order of the Board. Shall relinquish until further order of the Board his right to prescribe, administer, dispense, order, or possess Schedule II and II-N controlled substances, as defined by the Georgia Controlled Substance Act. Shall not provide professional or other medical treatment for any employees, past or present, of the Respondent. This Order shall not constitute any admission of misconduct on the part of the Respondent or be used as evidence of misconduct at any other proceeding before the Board. This matter shall be disposed of through a hearing.

Minizide® Mini-Marathon Spotlights the Need to Keep Drug Therapy Compatible with Exercise

Fenner McConnell of Pensacola, Florida, and Evelyn Zerfoss of Nashville, Tennessee, were the overall winners in the Minizide Mini-Marathon held in Atlanta. McConnell finished the 5-kilometer (3.1 mile) race in 17:07 and Zerfoss finished in 20:45.

Physicians and other attendees at the 76th Annual Scientific Assembly of the Southern Medical Association participated in the race. It was run to emphasize a relatively new idea in cardiovascular therapy — the need for compatibility between prescription-drug therapy and physical activity.

Speaking at the post-race awards ceremony at the Peachtree Plaza Hotel, George Sheehan, M.D., noted cardiologist, author and runner, explained that when prescribing medication for hypertension, doctors often do not sufficiently consider other factors in a patient's daily life.

For example, does the patient run or participate in other exercise regularly, or is the physician recommending that the patient exercise regularly? If so, "the high blood pressure medication prescribed for these individuals should permit the body to respond to its need for additional oxygen and permit patients to continue with their normal routines," Dr. Sheehan said.

"Jogger's Blockade"

"Alpha-blocker antihypertensive therapies, such as Minizide® (prazosin HCl/polythiazide), permit the body to respond more normally — both centrally in the heart and peripherally in the muscles — when involved in exercise. Other agents, in contrast, inhibit the heart's ability to speed up and, more importantly, decrease blood flow and necessary metabolic processes in muscles. This severely limits exercise tolerance.

"In other words, it makes sense that if a patient who runs or exercises regularly is taking medication for hypertension, the drug therapy should not interfere with the normal physiological response to exercise."



George Sheehan, M.D., center, Joe Nettles, M.D., # 468 from Savannah, and other physicians and attendees of the 76th Annual Scientific Assembly of the Southern Medical Association, participated in the 5-kilometer Minizide® Mini-Marathon along the streets of downtown Atlanta.

MEDICAL MEETING CALENDAR

DECEMBER

18—*Atlanta:* **Depression and Anxiety: Treatment and Advances.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

JANUARY—1983

13-14—*Atlanta:* **Imaging 1983: Computed Tomography, NMR, Ultrasound.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-22—*Atlanta:* **Basic Course in Phacoemulsification and Extra-capsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

30-Feb. 3—*Cancun, Mexico:* **5th Annual Scottish Rite Pediatric Postgraduate Course — Pediatrics in Review.** Category 1 credit. Contact Judson Hawk, Jr., MD, Scottish Rite Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/256-5252.

FEBRUARY

5-13—*Limone, Italy:* **7th Annual Conference on Pain — Chronic Pain: An International Epidemic.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-25—*Park City, Utah:* **Urology in the Wasatch Mts.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-26—*Augusta:* **Eighteenth Annual Family Practice Symposium.** Category 1 and AAFP prescribed credits. Contact Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-March 5—*Breckenridge, CO:* **8th Annual Snow Job in GYN/OB.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. School of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

MARCH

1-4—*Durango, CO:* **6th Annual Symposium on Emergency Medicine.** Category 1 and AAFP prescribed credits. Contact Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

9-11—*Augusta:* **Electrocardiography and Cardiac Therapy.** Category 1 credit. Contact Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

24-25—*Atlanta:* **Practical Use of Antibiotics: Update For the 1980s.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

26-27—*Augusta:* **Spring Meeting, Georgia Chapter, American College of Surgeons.** Category 1 credit. Contact LaMar McGinnis, M.D., 365 Winn Way, Ste. 201, Decatur 30030. PH:404/292-2700.

27-29—*Atlanta:* **MKSAP VI Part II—ACP.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

28-30—*Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

28-30—*Augusta:* **Genetics for the Practitioner.** Category 1 Credit. Contact Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

APRIL

6-8—*Atlanta:* **Techniques in Orthopaedic Surgery.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-8—*Atlanta:* **Otolaryngology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-8—*Atlanta:* **Internal Medicine.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-9—*Lake Lanier Islands:* **Update of Hepatobiliary Diseases.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

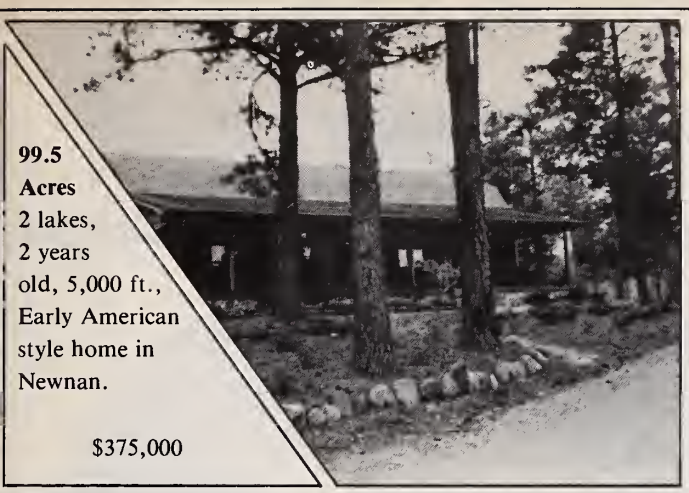
7-9—*Atlanta:* **Pharmacology For the Anesthesiologist.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

8—*Atlanta:* **Neurology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

9-10—*Atlanta:* **Hemodynamic Monitoring.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

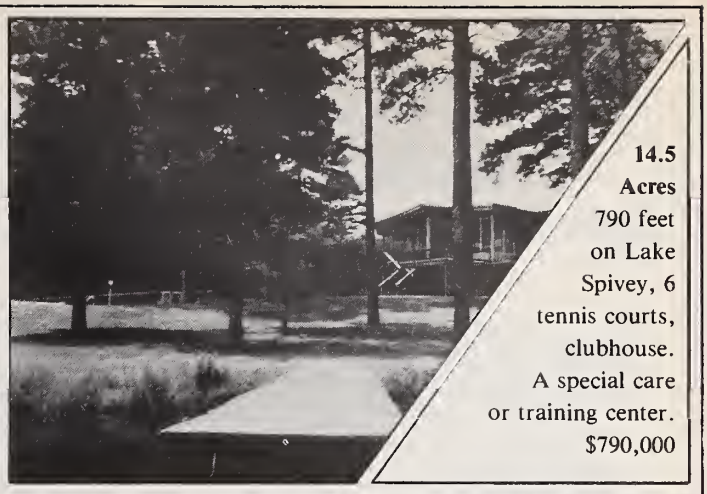
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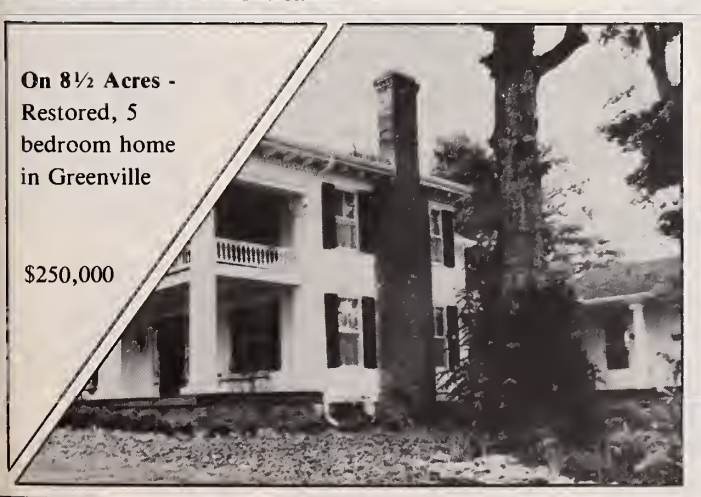
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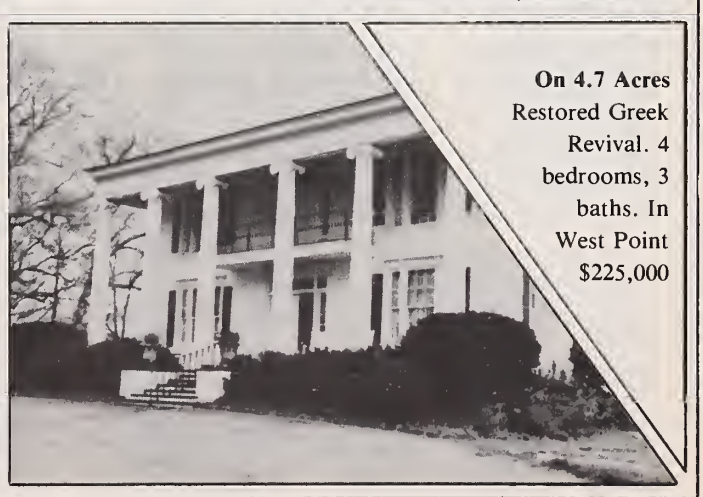
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JOURNAL
of the medical association of
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The Law — The Legislature — Your Practice

RUSTY KIDD and JAMES A. KAUFMANN, M.D., *Atlanta**

The Georgia Legislature, which convenes Monday, January 10, 1983, will probably consider 3,000 plus bills. Among these, well over 1,000 will pass and become THE LAW.

These LAWS will govern your life, your taxes, your patients, and your medical practice habits. If trends are a viable scale as to what to expect, at least 80 bills will be considered by the 1983 General Assembly that deal with medical care.

As of the writing of this article, the MAG Legislative Committee is already aware of several medical items that will result in legislation for the General Assembly in January. They are listed below for your benefit.

If you feel strongly enough about one of these issues you should contact your State Representative and State Senator informing them of your thoughts on an issue that will be before them in January.

Informed Consent

Legislation will be introduced to require physicians to provide the patient with an in-depth informed consent form prior to any surgical procedure. Said form will list *all* possible risks involved with the surgery.

This legislation, initiated by the Womens Coalition for Medical Freedom, Inc., is the first step in an attempt to require physicians, along with their all inclusive consent form, to list all possible alternatives to surgery.

Physician Delegation of Medical Acts

The MAG will initiate legislation which will specifically state that a physician and surgeon licensed by the Composite State Board of Medical Examiners in the performance of his duties can delegate medical acts to his employees. The physician assumes total liability and responsibility of these acts.

This law is needed due to an interpretation by an Assistant Attorney General that only a medical doctor or a licensed speech pathologist and audiologist could perform hearing tests. This obviously means an M.D. could not designate his personally trained employee to conduct a hearing test.

Nurse Practice Act

The Georgia Board of Nursing and the Georgia Nurses Association will initiate a total rewrite of the Nurse Practice Act. This new act will include the "Practice of Nursing by a Registered Professional Nurse," "Advanced Nursing Practice" and "Practice of Nursing by a Licensed Undergraduate Nurse."

There is a difference of opinion as to the degree of independent medical acts the Registered Professional Nurse and the Advance Nurse could perform without medical supervision. This is the area of controversy of this proposed bill which will ultimately be decided by the members of the Georgia House of Representatives and the Georgia Senate in January.

Certificate of Need

Legislation has been proposed to increase the dollar threshold for C.O.N. in Georgia. This proposal *does not* add to existing law C.O.N. activities for physicians' offices.

* Mr. Kidd is Associate Executive Director of the MAG and Director of the Legislative Division; Dr. Kaufmann is Chairman of the MAG Legislative Committee and practices internal medicine in Atlanta. Send reprint requests to Mr. Kidd at 938 Peachtree St., NE, Atlanta, GA 30309.

Immunity — State Mandated Programs

MAG will initiate a bill which would provide immunity to physicians who administer medications, etc. in accordance with state mandated programs.

Example: Pre-school immunizations. Georgia law mandates children be immunized prior to entering schools. Physicians who administer these immunizations would be immune from suit for adverse reactions, etc. from the administration of the immunizations.

Tort Reform — Professional Liability

MAG, along with MAG Mutual, is working with the Georgia Hospital Association, the American Insurance Association, and numerous business coalitions on health care costs to sponsor legislation which will assist in stabilizing professional liability premiums and enable MAG Mutual premiums to continue to be significantly lower than other carriers in Georgia.

Removal of Dismissal Clause

Currently Georgia law permits the plaintiff one jury dismissal at whatever time he chooses. This law, frequently used, lets the plaintiff end the trial by dismissing the jury at any point during the trial up to the time the verdict is read.

The legislation that will be introduced would *repeal* that law.

Professional Liability Committee

The new Governor will be requested to appoint a Special Governors Committee on Professional Liability for the purpose of studying the issue and recommending remedial legislation to the Georgia General Assembly.

Child Restraint

The MAG, in cooperation with the Georgia Chapter of the American Academy of Pediatrics, will initiate legislation to require all children under the age of 5 be in an approved child restraint seat while in a moving vehicle.

Behavioral Science Act

There will be a *proposed* law introduced to establish a *Behavioral Science Practice* Act. This proposed act will define behavioral science as "a body of knowledge relating to human behavior, both individually and collectively, including but not limited to the prediction and modification of both behavior and attitudes."

Behavioral science specialties means the specialties of professional counseling, social work, and marriage and family therapy.

Chiropractic

The Georgia Chiropractic Association will initiate legislation to redefine the scope of practice of Georgia chiropractors. This proposal states: "Chiropractors who have complied with this chapter shall have the right to adjust, examine, analyze, diagnose, and treat patients according to specific chiropractic methods."

Chiropractic Advertising

Legislation will be introduced to limit the degree of *misleading* advertising done by chiropractors throughout Georgia. This proposed bill will also require, in detail, that said advertisements state what type of clinic is doing the soliciting.

Chiropractors — Third Party Reimbursement

Legislation will be introduced to limit mandatory third party reimbursement to chiropractors.

At least 80 bills will be considered by the 1983 General Assembly that deal with medical care.

Chiropractors — X-rays

Possible legislation is being pursued to limit the number and qualifications of individuals performing the x-rays currently being done in chiropractors' offices.

Physicians' Assistants

Legislation will be proposed to require all future physicians' assistants to pass the exam offered by the National Commission for the Certification of Physicians' Assistants.

This proposed law would require an amendment to the Medical Practice Act which certify all PAs in Georgia.

Naturopaths

There will be an attempt to re-establish a State Licensing Board for Georgia Naturopaths. Said new act would define the practice of naturopathy and establish qualifications of their educational requirements.

A similar act was repealed in 1956.

Veterans Preference Points

Current Georgia law requires that veterans who take the Flex Exam administered by the Board of Medical Examiners, who license all Georgia physicians and surgeons, be awarded an additional 5 points because of their veteran status.

The Board of Medical Examiners does not approve of this and would like to see this law changed.

Division of Cancer Control

The MAG will seek to increase state funding of the Cancer State Aid Program, Cancer Screening Program, and the Cancer Registry.

The MAG Legislative Committee will report on these and other issues weekly in the *Legislative Bulletin* beginning January 3. If you desire additional information on any of the above, please contact the Legislative Division of MAG. Be on the lookout for this very important bulletin while the legislature is in session. It contains information you need to know and act on.

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Child Services

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

Adolescent Psychiatric Program

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

Alcohol and Drug Rehabilitation Program

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

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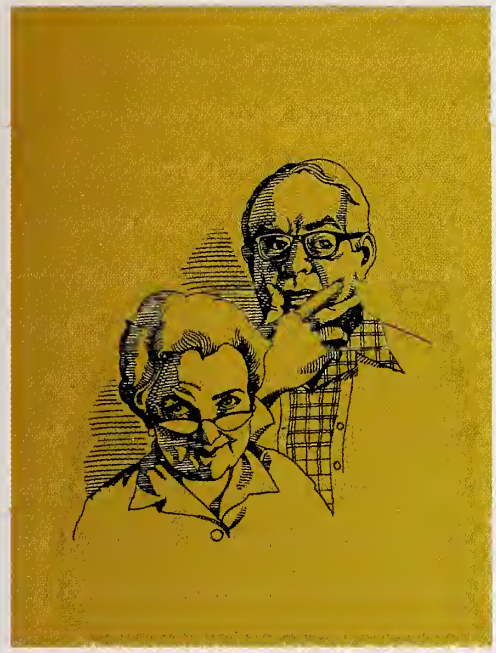
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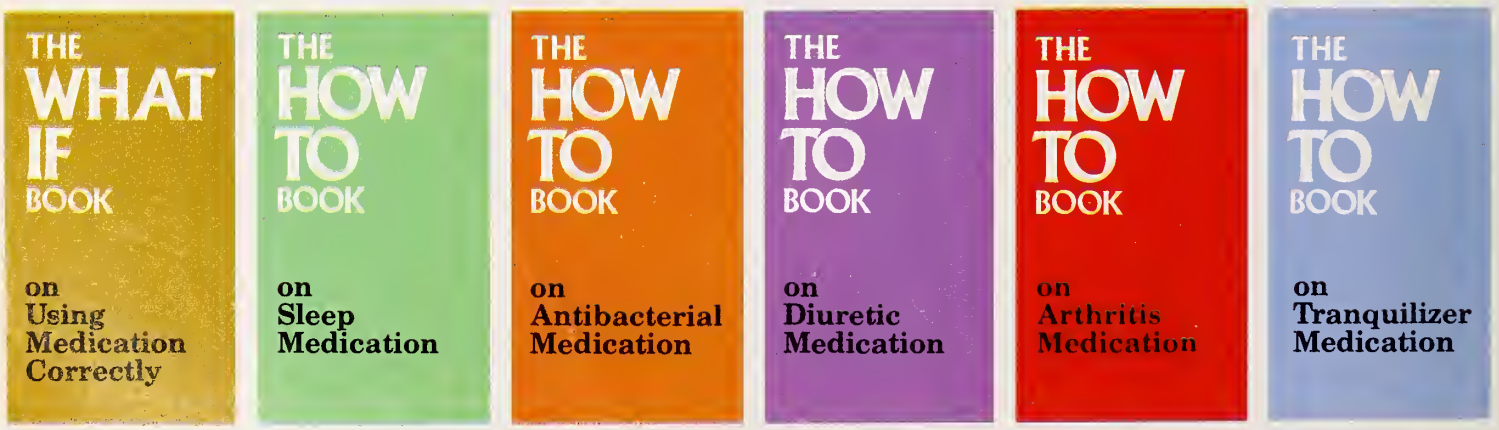
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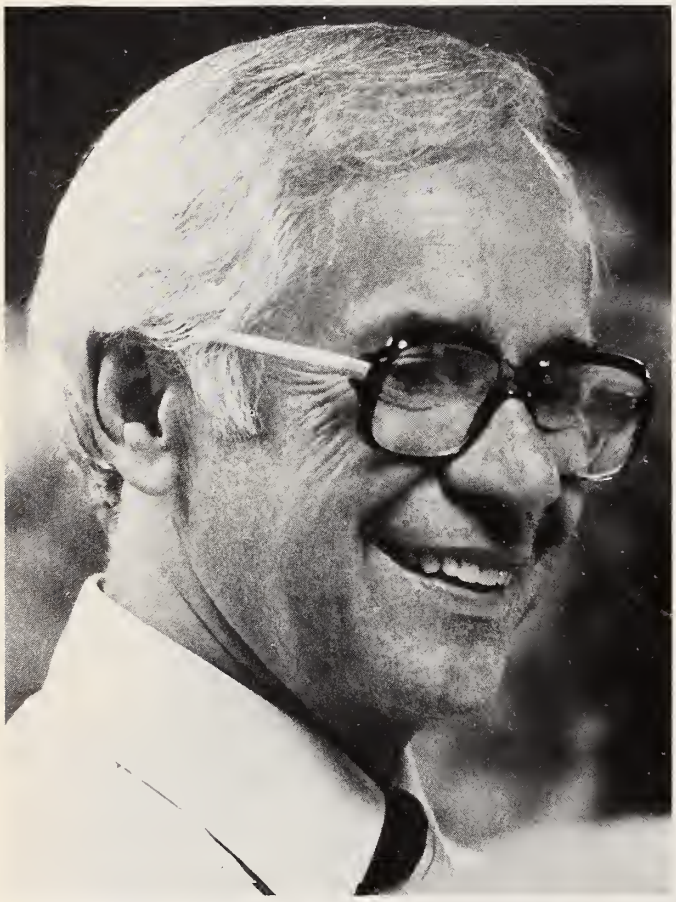
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An interview with Georgia's new Congressional representative whose roots are in the medical profession.

Dr. Rowland Goes to Washington

EVELYN WARD GAY, ***Decatur****





Georgia's newly elected congressional representative, Dr. Roy Rowland, and his wife, Luella, are looking forward to their new responsibilities in the nation's capital. Asked if his long campaign had been tiring, Dr. Rowland responded, "No, you don't get tired when you are doing something you love."

"IF A DOOR OPENS, you walk through it," says Dr. J. Roy Rowland, former family practitioner of Dublin.

The right door finally opened for him in 1982, and he gave up his medical practice to enter the race for a seat in the national Congress as a representative from the Eighth District. On Jan. 3, 1983, the winning Laurens County Democrat will be sworn in to serve his first term in Washington.

Although for the past 28 years he has been a busy and very successful physician taking care of the medical needs of many of the people in the Dublin area, he already has become known as an effective

* Mrs. Gay is the corresponding secretary and former historian of the Auxiliary of the MAG. Send reprint requests to her at 911 Vistavia Circle, Decatur, GA 30033.

politician by virtue of his six consecutive years in the Georgia General Assembly.

"Medical practice is very satisfactory as a means of serving the people," he declares, "but public service is similar and gives an opportunity to reach and help more people on a broader basis."

Dr. Rowland had considered entering the Georgia governor's race this year, but felt that the entry of Bo Ginn into the field of candidates "eroded his base" somewhat, so opted for the national body instead. He had thought about trying for Congress as early as 1978, he says, but finalized his plans in that direction only after deciding not to go for the governor's office.

What does he expect to accomplish while in the nation's capital? He has several goals. First, he is dedicated to working for the interests of his state's small family farmers, since 4/5 of the people in the district from which he comes are engaged in agricultural pursuits.

"Their futures are in jeopardy," he says, with deep concern for the welfare of the independent small farmers he knows.

Of course, he assures, he also is interested in medical legislation. While participating in state government, he had begun working for passage of a bill dealing with "Living Wills," but was not successful in getting it through both Houses. He is confident, however, that someone else will take up his project and go on with it. He also fought and won his battle to kill HMO legislation. A "Certificate of Need" bill which he opposed was passed but with several important amendments.

Dr. Rowland and his wife, the former Luella Price, both natives of Wrightsville, do not plan to leave Dublin for good, although they will be moving into a new townhouse condominium which they recently purchased only one block from the nation's Capitol Building. They will keep their Dublin home and spend as many weekends there as possible. He will miss his former colleagues in the 5-member group of physicians, where he has spent so many years, but is satisfied that they will soon find a suitable younger man to take his place. The life of a large metropolitan city will be new and different for the Rowlands, he admits, but they anticipate the change with great enthusiasm.

Does Mrs. Rowland enjoy politics? he is asked. He answers without hesitancy. "She is my No. 1 asset," he says of his high school sweetheart, who is the mother of his two daughters and one son, none of whom has chosen to enter either medicine or politics. The daughters are both married; one lives in Warner Robins, the other in Jacksonville. The son lives in Middleberg, Florida.

Roy Rowland had been interested in medicine since his earlier days in Wrightsville. But as a teenager completing his second quarter as a freshman student at Oxford College, he volunteered for service in the United States Army in 1944 and became a machine gunner seeing action in the European Theater of Operations. He entered the Army as a private and was discharged 2 years later as a sergeant with two battle stars, the combat infantry badge, and a Bronze Star for valor. Fortunately, he says, he returned without a Purple Heart.

Following military service, he resumed his studies, first at South Georgia College at Douglas, and later at the University of Georgia in Athens. He then entered the Medical College of Georgia in Augusta and was graduated from there in 1952. After two years of internship at a Macon hospital, he practiced family medicine for 6 months in Swainsboro, and from there went to Dublin.

Asked if his long and successful campaign for a seat in Congress had been tiring, Dr. Rowland immediately responded: "No, you don't get tired when you are doing something you love."

He says he enjoys meeting people, talking with them, and trying to help solve their problems. He gets so much pleasure out of politics, in fact, that he has little time left for what used to be his three favorite forms of relaxation — hunting, fishing, and playing golf.

The new Congressman, who hopes that his first election will be just the beginning of a long period of rewarding service, will be the second Georgia physician in recent times to win a place in Washington. Dr. Larry McDonald, a former Atlanta urologist, has been a representative from the Seventh District for several years.

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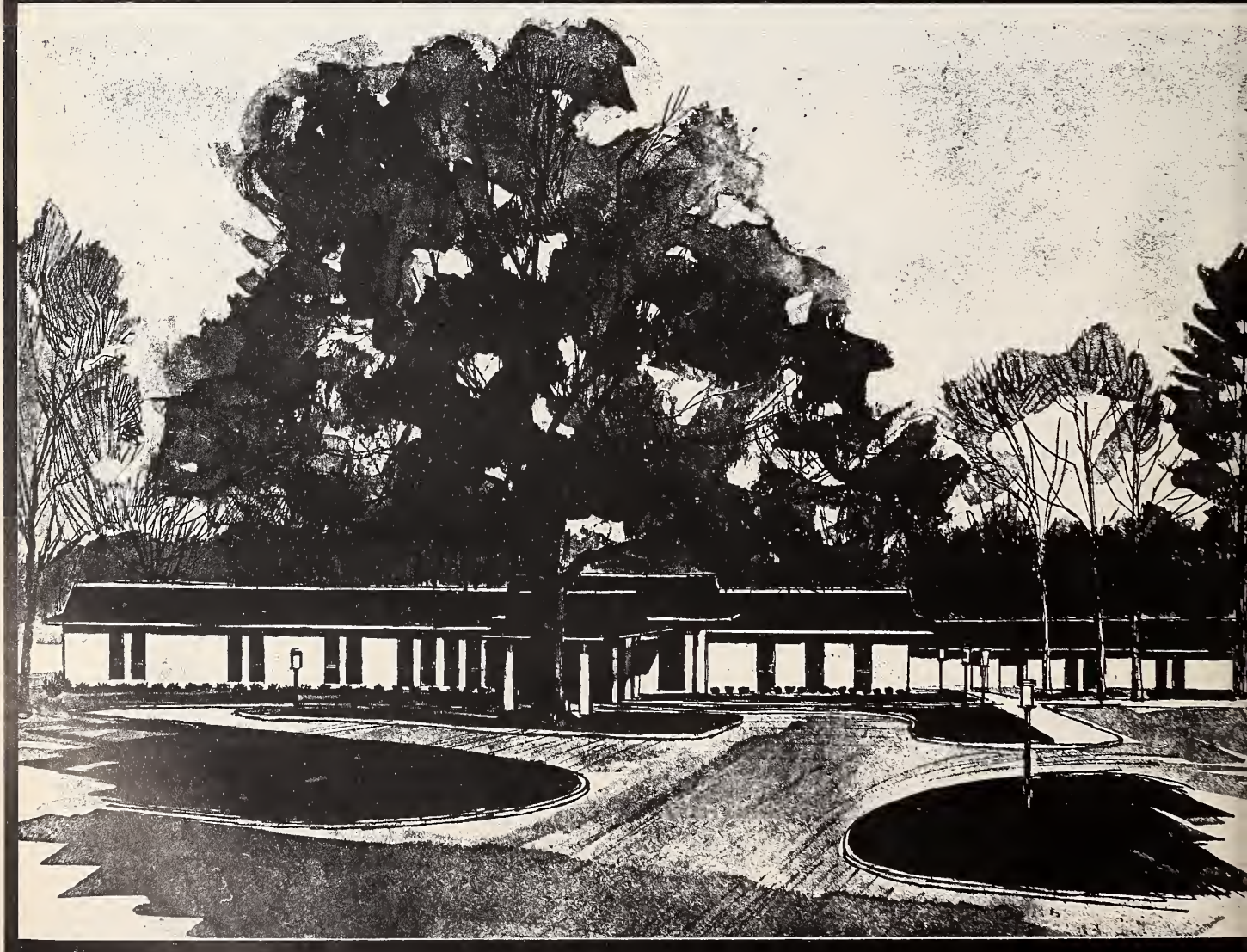
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Flexible fiberoptic bronchoscopy has become a viable alternative for the removal of aspirated foreign bodies when the medical condition of a patient precludes the use of a rigid bronchoscope.

Endobronchial Foreign Body Removed by Flexible Bronchoscopy

L. F. ARANGO, M.D., B. A. CHAUDHARY, M.D., and W. A. SPEIR, JR., M.D., *Augusta**

Abstract

Rigid bronchoscopy remains the procedure of choice for retrieval of foreign bodies from the tracheobronchial tree. However, flexible fiberoptic bronchoscopy has become a viable alternative when the medical condition of a patient precludes the use of a rigid bronchoscope. In addition to a brief review of the literature, we report the use of a flexible fiberoptic bronchoscope to remove a tooth from the right lung of a patient with cervical spinal fracture.

Introduction

Retrieval of a foreign body from the tracheobronchial tree is a challenging problem. It has been customary to remove foreign bodies from the lungs by rigid bronchoscopy with extraction forceps or special instruments.[1, 5] Many times, however, the foreign body is out of visual range of the rigid bronchoscope, particularly when the object is located in segmental or smaller bronchi.[6] Moreover, the underlying medical problems of a patient may preclude, or make more difficult, the use of a rigid bronchoscope; patients with fractures of the jaw, cervical spine, or skull and patients on mechanical ventilation are examples. Unless surgery is contraindicated, thoracotomy with transpleural bronchotomy is performed to prevent complications in such patients. When neither rigid bronchoscopy nor surgical intervention is practical, however, flexible fiberoptic bronchoscopy may well be indicated. A number of reports have been published which describe the use of fiberoptic bronchoscopy for the removal of various foreign objects. We report a case in which fiberoptic bronchoscopy was used successfully to remove a tooth from the right lung.

Case Report

A 51-year-old man was admitted to the Medical College of Georgia/Talmadge Memorial Hospital with a history of head trauma and grand mal seizures.

Physical examination revealed a man in post-ictal state with stable vital signs, a very tender neck posteriorly, poor dentition, and diffuse inspiratory-expiratory crackles over both lung fields. Chest roentgenogram was interpreted as normal. Cervical spine roentgenograms revealed Forestier's disease and fractures at the levels of C2-3 and C3-4.

The patient was started on anticonvulsant medications. On the fourth hospital day, the patient developed a temperature of 39° C with no increase in his white blood cell count. A repeat chest roentgenogram revealed an alveolar infiltrate in the basal segment of the right lower lobe. Antibiotics for possible aspiration pneumonia were begun, but the fever persisted. Five days later, a chest roentgenogram again revealed right lower lobe alveolar infiltrate; but this time a density in the area of the proximal right upper lobe bronchus was identified. The radiologist interpreting the film thought it was highly suggestive of an aspirated tooth (Figure 1). The pulmonary medicine service was consulted and, because of the cervical vertebral fracture, the decision was made to attempt the retrieval of the foreign body with fiberoptic bronchoscopy.

The patient underwent bronchoscopy; a large

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Figure 1 — Chest roentgenogram showing foreign body (upper arrow) and right lower lobe pneumonia (lower arrow).

foreign body, presumably a tooth, was seen at the distal end of the right bronchus intermedius with almost complete occlusion of the right lower lobe bronchus. A basket forceps was passed, and the tooth was entangled in the basket. With the forceps holding the tooth, the bronchoscope was removed. The patient tolerated the procedure well. The alveolar infiltrates improved slowly during the hospitalization, and the patient was discharged.

Discussion

The use of the endoscopic examination dates back to the end of the nineteenth century. In 1897, Killian first slid a tube into the trachea and bronchi and retrieved a fish bone. Since that time, rigid bronchoscopes have been used extensively in the retrieval of foreign bodies.

Even though rigid bronchoscopy remains the procedure of choice for removal of foreign objects, a small but gradually expanding body of knowledge indicates that the flexible fiberoptic bronchoscope has a role in foreign body removal.[10-24] Case reports describing the clinical experience in foreign object removal are summarized in Table 1.

The difficulty in obtaining a history of aspiration, combined with the radiolucent quality of many foreign objects, may result in delayed diagnosis and extraction, thus increasing the possibilities for

TABLE 1 — REMOVAL OF FOREIGN BODIES BY FLEXIBLE FIBEROPTIC BRONCHOSCOPY

Year	Reference	Foreign Body
1973	Wanner, et al[12]	Fragments of banana
1974	Ikeda[6]	Fish bone and dental drill
1974	Barrett, et al[13]	Gastric contents
1975	Zavala, Rhodes[14]	Suture with granulation tissue
1975	Klayton, et al[15]	Rubber ear plug
1976	Lillington, et al[16]	Ham bone
1976	Fieselmann, et al[8]	Two teeth
1976	Papamichael[17]	Pulp canal reamer
		Melon seed
1977	Smith[18]	Metal Pins
1977	Hargis, et al[19]	Ceramic tile fragment
1977	Rohde, et al[20]	Metal pin
1978	Cunanan[21]	Coins, buttons, etc.

pneumonia, abscess formation, empyema, or even death. The decision of whether to remove a foreign body by rigid bronchoscopy, flexible fiberoptic bronchoscopy, or surgical intervention should be based on (a) the age of the patient, (b) the size and location of the foreign body, (c) the availability of various grasping instruments, and (d) the experience level of the endoscopist.

Aspiration of foreign bodies usually occurs in the young, particularly in children under four years of age.[9] The flexible fiberoptic instrument is seldom used in infants or young children due to the small diameter of the tracheobronchial tree and to a child's inability to fully cooperate as necessary. The objects most frequently aspirated in this age group include vegetables (peanuts, popcorn, watermelon seeds, sunflower seeds, pumpkin seeds, corn, and dried beans), plastic objects (parts of broken toys, tiny plastic tops, broken rattles), hard candy, and chewing gum. Those most often recovered in adults and children over 14 years of age are hardware (broken pieces of ballpoint pens), dental objects (loose teeth, inlays), pins, and parts of surgical instruments.

Large foreign bodies in the trachea and mainstem bronchi should be removed with the rigid bronchoscope when possible.[11] A variety of grasping instruments are available. The retrieval basket is ideal for entrapping large objects and works well in recovering organic objects with volume, such as peanuts, beans, sunflower seeds, and chicken vertebrae. The wire claw is useful for objects which have a graspable surface. Biopsy forceps with short tiny jaws have been used successfully in the removal of straight pins.[1, 11, 14] Alligator grasping forceps are useful in holding metallic objects.[11] For objects tightly wedged in the airway, a fogarty catheter passed beyond the foreign object, followed by inflation of the catheter balloon, usually dislodges the object as the catheter is withdrawn.[14]

Extensive practical experience in flexible fiberoptic bronchoscopy, in addition to prior experience in

methods of foreign body removal, is essential; otherwise, serious harm may be done to the patient. Any of the following complications may occur because of improper techniques: (a) displacement of the foreign body to an unfavorable position so that recovery requires bronchotomy; (b) trauma to the bronchial tree resulting in infection, bleeding, or perforation; (c) airway obstruction secondary to loss of the foreign body in the subglottic area during recovery (the head of the patient's bed should be kept elevated to prevent this potentially serious complication); (d) breakage of an organic object (e.g., a peanut) into pieces by application of the improper extraction tool (forceps) so that retrieval becomes difficult, if not impossible; and (e) any complications arising from inappropriate attempts to aspirate foreign bodies in infants and young children.[14]

There are definite advantages to the use of fiberoptic bronchoscopy for foreign body extraction. The flexibility of the bronchoscope yields an increased range of visualization and motion, in addition to facility of insertion, even in patients with fractures of jaw, cervical spine, or skull, in patients with severe deformities of the cervical spine or pharynx, or in patients on mechanical ventilation. The patients also experience less pain and are more comfortable due to the flexibility of the bronchoscope. There is less irritation to the tracheobronchial mucosa, and the foreign bodies are removed with relative ease. Moreover, there is decreased risk with the use of topical anesthesia rather than general anesthesia.[3]

To conclude, fiberoptic bronchoscopy is a useful technique for the removal of aspirated foreign bodies in patients who have contraindications to rigid bronchoscopy.

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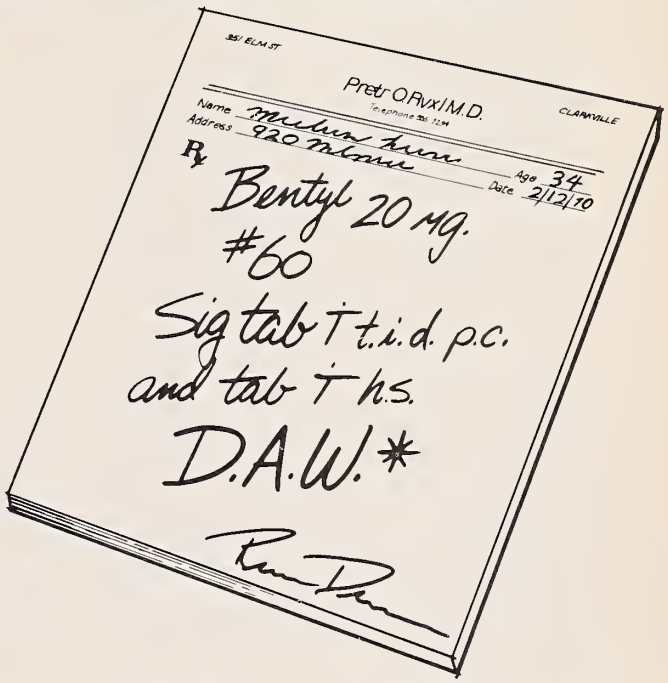
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*This drug has been classified "probably" effective for this indication.

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Reference:
1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

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Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.
For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.
Use with caution in patients with:
Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.
Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.
Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage
Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)
Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.
Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.
NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
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The author opines on sibling rivalry.

"My Billy Hates My Susan"

SANFORD J. MATTHEWS, M.D., *Atlanta**

EVERY PEDIATRICIAN has listened to the fear expressed by mothers about being able to love the second child as much as she does the first. This emotion, deeply felt and disconcerting, plagues many women during their second pregnancies. It is frequently the reason for deferred pregnancy and is often the cause of anxiety and tension during pregnancy. Ironically, however, this concern predicts the acceptance of the new baby by both the mother and the first child.

It is pleasant to watch these previously worried and uneasy mothers change after the new sibling is born. The same surges of love and nurture come over her, just as they did after her first delivery. The same attachment, so overpowering and sweet, which characterized her thinking after her first baby, returns to dominate her thinking again. It transforms her into that magnificent phenomenon of nature: the nurturing, loving, instinctive, caring creature who is the new mother, free of concerns about worldly things, intent upon the survival of this new happiness in her life, jealous of its care, and intent upon carrying out her mission.

The Gift of a Sibling

Before discussing sibling relationships, it is well to reflect on what a sibling means to a child. In addition to love, which is every child's right and expectation and the greatest gift that parents can give a child, the gift of a sibling far surpasses any other a child can receive. It certainly transcends the gift of property or title. Indeed, when we review what might be appropriate as a gift for a beloved child, it is difficult to imagine anything more dynamic, more fulfilling, more happiness giving than the gift of one's own brother or sister.

That brother or sister will share with his sibling the happiness and love of the most significant love objects of their lives: their parents. They will share this love and the memories of it throughout their lives and recall the beauty and sweetness of that love in times of joy *and* sadness. Their relationship will endure when a hostile world begins to work its hardship on them. The advice and solace which they give each other will play a major role in their ability to cope with that hostility. They will fight, argue, share, and dispute. They will experience justice and injustice, discipline and permissiveness in the nurturing environment of family love. These lessons will be an integral part of their maturing, made all the more effective by the mutuality of their sibling relationship and the sharing it implies.

When I discuss these thoughts with parents, it is almost inevitable that tears of happiness and joy fill the new mother's eyes. It is a most touching reaffirmation, if one is needed, of the excitement, the commitment, the love, and the joy that every mother feels toward her child, now children. The glistening eyes and the grateful expression eloquently testify to the acceptance of the message, reaffirming as it does emotions that have been welling up since the delivery of the second child.

Love Divided But Not Diminished

Having waxed poetic for a bit, we must now confront the realities of life with the firstborn, who waits impatiently to test his parents' strength with the new found weapon they have given him: his sibling. Armed as they are with a positive attitude, namely, that nothing has been taken away and a great deal has been added, their response to this assault should be positive, effective and, most of all, reassuring.

It is axiomatic that the firstborn child receives a dose of love and affection that is above and beyond

* Dr. Matthews practices pediatrics. He is the author of a new book on child rearing, *Through the Motherhood Maze*. Send reprint requests to him at 1938 Peachtree Rd., NW, Ste. 207, Atlanta, GA 30309.

his needs. In spite of every effort to moderate it, mother and dad, in otherwise happy circumstances, lavish a degree of care and nurture on their firstborn which is the marvel of psychologists and child development experts. No one would deny that this care borders on the excessive in quantity and quality. It is my experience that the only circumstance which modifies and moderates this avalanche of love and caring is the appearance of a sibling.

Regressive behavior should be understood for what it is: a controlling device. It should not be ignored but understood.

A sibling, perforce, divides this love in two. That division is the result, if nothing else, of the logistics and economics of the situation: the mother being, despite her best efforts to refute it, a human being. An assessment of the quantity of parental love which is available for the new pair would lead anyone to agree that the quantity is more than significant. As always, nature provides a fail-safe mechanism, and mother responds with an outpouring of love and nurture which satisfies the needs of both children, mends all hurts, and fills up the cup of child love to overflowing.

It is important that mother be convinced of this, as the effort to improve on it will lead to exhaustion and grief, with guilt lingering not far behind to add its debilitating burden.

The Adversary Relationship

Siblings, by instinct, love each other. History reinforces that notion, the exceptions to it being the proof. There is only one force which can come between the love of silbings for each other and that is the force of parental love.

When the new baby comes home, the firsborn immediately sees it as a weapon with which to exercise control over his parents. Parental control is, after all, what the child strives for throughout childhood. The extent to which he succeeds in achieving parental control is the extent to which he becomes miserable and, concomitantly, makes his parents miserable. This "adversary" relationship is ongoing. It characterizes all transactions between parent and child. The goal of this behavior is control.

Control has been variously defined in child development. The Freudians have some bizarre notions about what the child is up to. Some observers mistake attention for control, thereby missing the vital point that attention pervades a child's life, making more of it a liability even under these circumstances. Control is best thought of as having parents in thrall or totally enmeshed in transactions revolving around the controlling child: thoughts, actions, plans, etc.

While this control might be appropriate in many short-term circumstances, its long-term, nonstop consequences are manifestly destructive. This adversary relationship occurs in the setting of great love and license, given willingly and joyfully by caring and committed parents. The adversary relationship is a reflection of that love, and in the absence of that love, no such relationship exists. Thus, a child who is unsure of parental love would not dare to to try that love with the naughtiness or misdeeds which a beloved child would find reasonable.

Parental response to this controlling behavior should be firm and, in its turn, controlling. An equilibrium is established in which everyone shares to his benefit: the mother with a tractable, if constantly challenging child, the father with a wife who is at peace, and the child with limits which are always to be tested, but finite and reasonable.

The Firstborn's Game of Control

A new sibling presents a child with a marvelous new weapon to use in the adversary relationship. It is my experience that the more resourceful and loved a child is, the more vigorously and imaginatively he will use his siblings to gain parental control. It is well to give parents some practical hints on how their child might use his sibling in the power struggle, so that they will be ready for the game.

The first and most primitive device is regression. This can take the form of baby talk, wetting his pants, crawling, whining, and a whole litany of complaints calculated to disrupt a mother's routine and to suggest, however subtly, that the firstborn has unmet needs. Many children begin this behavior prior to to the sibling's delivery. If this regressive behavior is useful for a child, he will pursue it with vigor and enthusiasm. Fathers are particularly vulnerable to this ploy, anxious as they are for their sons to have an uninterrupted voyage toward manhood.

The gift of a sibling far surpasses any other a child can receive from his parents.

Regressive behavior should be understood for what it is: a controlling device. It should not be ignored but understood. When a child sees that a controlling device is unsuccessful, he will move on to another. Thus it is with regression. The second controlling behavior and the one most calculated to arrest the maternal heartbeat is the "I don't love you" ploy. This can be varied into "You love the baby more than you love me," "I love my daddy,

and I don't love you," "You love the baby, and you don't love me," etc. The variations are limitless, bounded only by the child's imagination.

It is well to remember here that mother and daddy's love for the first child is limitless. Taking an example from mathematics, I talk about this love as infinite. Infinity knows no bounds, brooks no comparisons, cannot be divided or put into barrels. It is folly to consider that more or less is accruing to one or another child. It is only when the natural process of giving that love is artifically considered that problems arise.

The child is always secure in his parents' love. When excuses and explanations of that love are given, the child becomes confused and anxious. Thus, if parents overreact to a ploy, the child will seek explanations for that overreaction and find one. This can be the prelude to a welter of misunderstanding at a very primitive level.

I recall one mother who suspended discipline in response to this ploy. Her child progressively exhibited problem behavior until she sought my counsel. I reinstituted all previous rules and punishments as they had been before the sibling's birth. It wasn't long before she called and tearfully told me that when she had reprimanded her child, he did not cry but said, "I'm glad you spanked me, Mom, I didn't think you loved me anymore."

In spite of every effort to moderate it, mother and dad . . . lavish a degree of care and nurture on their firstborn which is the marvel of psychologists and child development experts.

The lesson is clear: In a loving home a new baby is an event to be celebrated, an event to be seen as an embellishment of family love and resources. It is an addition of love and happiness to the parents and the child. Nothing can approach it in its enriching and nurturing effects. Nothing should mitigate the joy and happiness which it brings to a family.

"My Billy Hates My Susan"

But what of the children who have been successful in using their siblings in the power struggle for control? What of the child who is jealous of his sibling, who has extracted concessions from his parents in the name of good parenting? What about the child who steadfastly claims that he hates his sibling and who maintains his stance even after listening to the tearful pleas of his mother and accepting her bribes?

It is well to remember under these circumstances that children are incapable of being really jealous. Jealousy is an adult emotion which requires hormones and property to be felt. Certainly children have hormones, but they are to grow with. Certainly children claim property, but a frog in a box, a raggedy piece of blanket, and a soiled, but beloved doll hardly meet the adult criteria of property.

The only possession which children cherish and guard is their parents, and the only love which is totally meaningful to them is parental love. It is my belief that children are incapable of committing any of the seven capital sins. Indeed, it is ludicrous to think of it, yet parents discuss with me the deceit, lying, dissembling of their children with the gravity which a libertine might merit.

When controlling habits of speech, which is all they are, have become ingrained in siblings in their references to each other, it becomes important for partents to hear what their children are really saying. When behaviors suggest what might be interpreted in an adult as jealousy, it is well to probe and interpret what the behavior really signifies.

If I hate and am jealous of Susan, says and behaves Billy, I will control my parents.

The simple answer lies first in understanding what the words and behaviors mean, then, in responding in the light of that understanding. You will be amazed at the love feast that follows.

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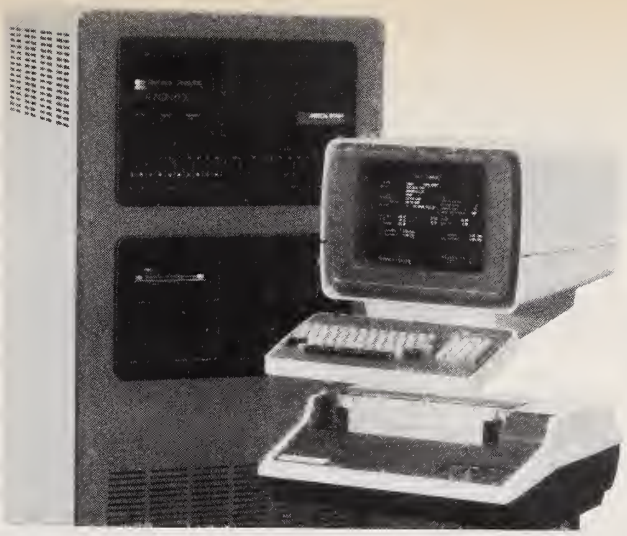
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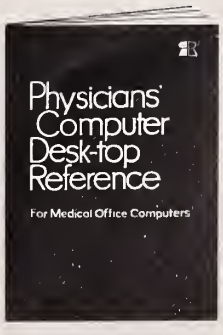
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Pinworms work the night shift



Artist's interpretation:
The nocturnal egg-laying of the female pinworm causes acute perianal itch...making children shift sleeplessly through the night.

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Antiminth® (pyrantel pamoate) has a unique, rapid immobilizing effect on worms. Unlike mebendazole, which blocks glucose uptake—slowly "starving" helminths to death—Antiminth quickly acts on the neuromuscular junction to promptly paralyze parasites.

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Antiminth offers ease of administration and patient tolerance. "...when compared to the other single dose agents available, [Antiminth] has the advantage of being non-staining and may be better tolerated."[2]

The dosage form children like

Antiminth is available as a pleasant tasting, caramel-flavored oral suspension. Effective in just



one dose against pinworm and roundworm—in both children and adults—Antiminth is easy-to-administer and easy-to-take.

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In some parts of the world, large populations are afflicted with helminthic infections. Physicians in endemic areas have become experts on parasitic diseases—and have come to rely on Antiminth for the rapid cure of infestations. Antiminth is recommended as an agent of first choice for pinworm and roundworm by leading medical authorities.[3]

Warnings

Usage in Pregnancy Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions

Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions

The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration

Children and Adults Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

References 1. Pitts NE, Migliardi JR: *Clinical Pediatrics* 13:87, 1974. **2.** Modell W: *Drugs of Choice* 1980-1981. C. V. Mosby Co., St. Louis, 1980, p. 362. **3.** Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*, 6th edition, MacMillan Publishing Co., Inc., New York, 1980, p. 1032.

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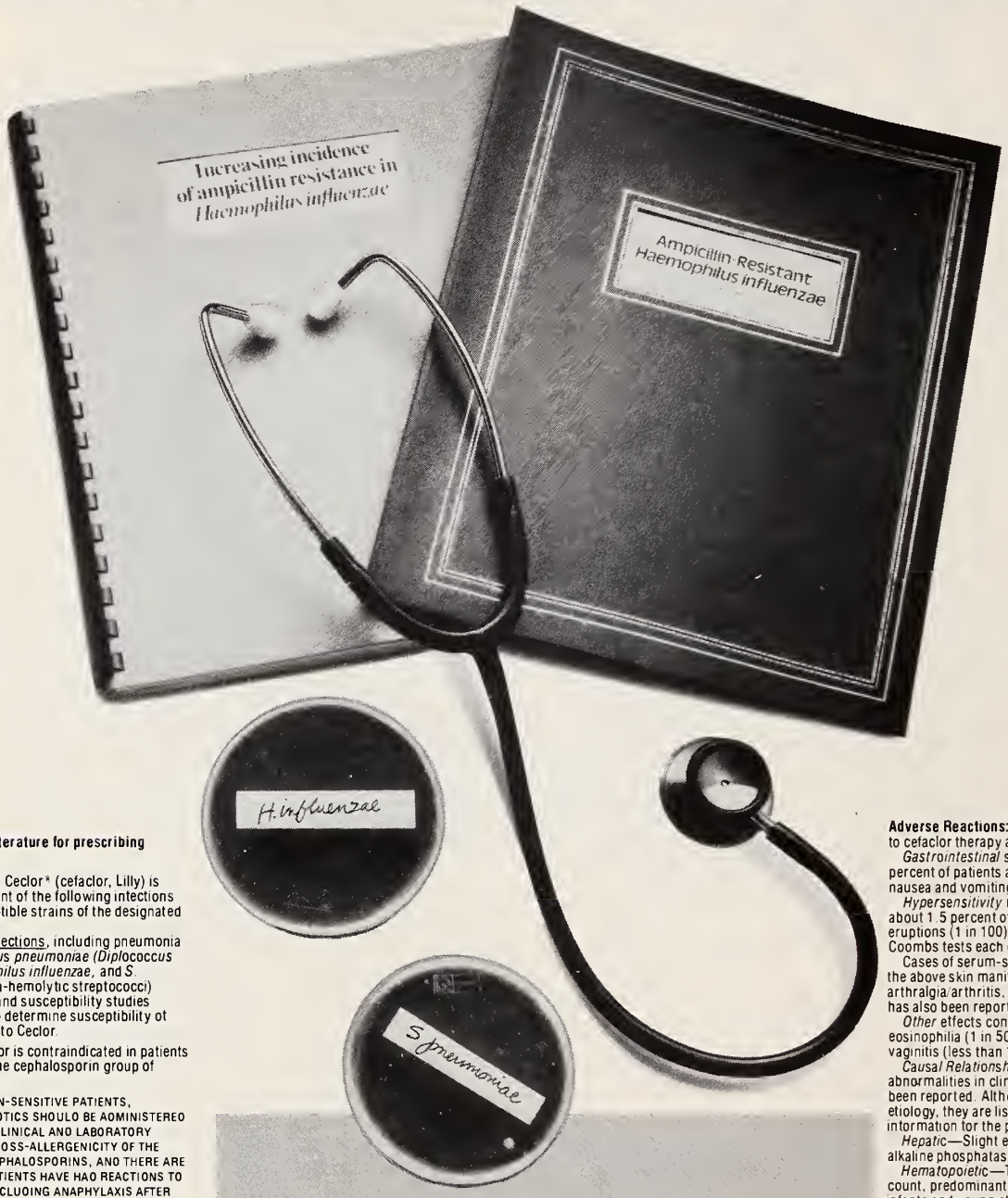
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Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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The Medical Fair offers a unique opportunity for establishing contacts between community recruiters and residents.

The 1982 Medical Fair — Largest Ever

GOULD HAGLER, JR., ***Atlanta****

REPRESENTATIVES of 44 Georgia communities and 99 resident physicians attended the 1982 Medical Fair and Pre-Practice Seminar on September 17-19 in Atlanta.

Attendance at the 1982 Fair was the highest in the history of the event, which is sponsored annually by MAG and seven other public and private organizations. In 1977, 1978, and 1979, MAG and the Southeastern Institute for Community Health co-sponsored the Physician Recruitment Conference and Pre-Practice Seminar, held in Callaway Gardens. The State Medical Education Board, the University of Georgia Cooperative Extension Service, and the Medical College of Georgia conducted the Augusta Medical Fair in 1979 and 1980. The two activities were merged in 1981 and 1982, and will continue on this basis in the future.

Other sponsors for the 1982 Fair were the State Medical Education Board, the Georgia Academy of Family Physicians, the Georgia Hospital Association, the Joint Board of Family Practice, the Medical College of Georgia, the Southeastern Institute for Community Health, Inc., and the University of Georgia Cooperative Extension Service.

The Fair has a two-fold purpose: to provide an opportunity for residents interested in practicing in small towns to meet with representatives of Georgia communities seeking new physicians; and to acquaint the residents and their spouses about the new problems they will face in the transition from training to practice.

Of the ninety-nine residents, forty-eight will be ready for practice in the coming year. Of these, nineteen are state scholarship recipients and are obligated to practice in cities of 15,000 or less in population. Two-thirds of all the physicians in attendance are in the specialities of family practice, internal medicine, obstetrics/gynecology, and pediatrics.



(L-R) H. Calvin Jackson, M.D., Kelley B. Dopson, Thomas L. Dopson, and David A. Wells, M.D., were among those attending the recent Medical Fair this year in Atlanta.

The cities represented ranged from Blairsville and Cartersville in the north to Cairo and Homerville in the south. They were represented by physicians, hospital administrators, businessmen, and other community leaders. To be eligible to participate, a town must have a hospital and a population of less than 15,000.

"It's amazing how the communities' efforts have grown more sophisticated since we started back in 1977," said M. Julian Duttera, M.D. Dr. Duttera is Chairman of the MAG Access to Health Care Committee and President of the Southeastern Institute for Community Health. "Nearly every booth had an audiovisual presentation, samples of local products, and a variety of information on life in the community. The community reps have become expert re-

* Mr. Hagler is an Executive Assistant with the MAG and staffs the Access to Health Care Committee. Send reprint requests to him at 938 Peachtree St., NE, Atlanta, GA 30309.



The winning community exhibit at the 1982 Medical Fair was from Ellijay.



Washington had an interesting exhibit. Shown here from left to right are Charles G. Lodge, Avola Callaway, Carolyn Lodge, and Ruth Pope.

cruiters. They learn fast how to present their hometowns to prospective physicians.'' Ellijay won the award for the most attractive community display. Of the 44 communities only eight were attending the Fair for the first time.

The Fair opened on Friday, September 17, with an orientation luncheon for residents and their spouses, at which the Medical Fair staff advised the residents how best to use the Fair. At the same time the community representatives were given tips on marketing their communities in the most effective way. Friday night the physicians and the recruiters got together for an informal mix and mingle cocktail buffet. All day Saturday was taken up with scheduled interviews. On Saturday night many communities entertained residents and spouses at dinner.

Through these social events and the interviews, the Medical Fair offers a unique opportunity for establishing contacts between community recruiters and residents. In the coming months, most residents will visit several communities before making their final choices.

Since its inception in 1977, the Medical Fair has succeeded in placing over 40 physicians in rural Georgia communities.

At the Pre-Practice Seminars, held Friday afternoon and Sunday morning, several panelists addressed key subjects for physicians entering practice. Andy Morley, M.D., moderated a discussion on ''The Selection Process'' in which Donald Waters, M.D., Steve Taunton, M.D., and Eugene Jackson, M.D., recounted their experiences for the benefit of the residents.

Charles Foster, administrator of the West Georgia Medical Center in LaGrange, discussed the same topic from the community and hospital viewpoint. The spouses heard Mrs. Taunton and Mrs. Waters discuss the selection process from the spouse point of view in a panel moderated by Camille Day, Executive Vice President of the Georgia Academy of Family Physicians. Walt Disher, President of Professional Dynamics, spoke on ''Beginning Your Practice: Professional and Personal Priorities'' and ''Practice Management Issues.'' M. Julian Duttera, M.D., discussed ''Making the Transition from Training to Practice,'' presenting the results of a survey of physicians recently entering practice.

Since its inception, the Medical Fair has succeeded in placing over 40 physicians in rural Georgia communities. Many good contacts were made at the 1982 Fair, and time will tell how many of these contacts develop into actual placement of physicians in small communities. The Medical Fair staff, representing each of the eight sponsoring organizations, have already begun planning for the 1983 Fair.

One Town's Success Story

''I couldn't have done any better,'' says Dr. Michael P. Hancock, a family practitioner who settled in Vienna, Georgia, in January, 1982. Dr. Hancock and his wife, Barbara, attended the 1981 Medical Fair and Pre-Practice Seminar in Augusta. From among the 40 communities represented at the Fair, they selected Vienna to be their home.

Both Dr. and Mrs. Hancock are natives of nearby Dawson, and they are happy to get back to small town life after years of medical school and residency in Augusta.

''Augusta is okay, but we don't like city life — it's too big and too hectic,'' commented Dr. Hancock. They wanted to settle in a small town, closer to home, and closer to the outdoors. Dr. Hancock enjoys outdoor recreation, especially boating and fishing.

Vienna is located on I-75, approximately 50 miles south of Macon. According to Dr. Hancock, the town is populated with ''down home country people'' who have made his family of 3 feel right at



Dr. Michael P. Hancock of Vienna, Georgia, is one physician who used the Medical Fair to locate a small community in which to practice.

home (the Hancocks have a 2½-year-old daughter). Dr. Hancock is one of four physicians practicing in Vienna full time; there are also a few consulting physicians who visit regularly. Vienna is served by the Dooly County Medical Center, a 35-bed facility.

Representatives of the community also attended the 1982 Medical Fair in their continuing effort to attract physicians.

"We could probably use a surgeon here full time," says Dr. Hancock. "The call schedule is pretty hectic, too."

Dr. Hancock practices in partnership with Dr. Joseph Christmas (who helped represent the community at the 1981 Fair) and Dr. Robert Garrett. The practice is busier than he expected, and he has also been impressed by the variety of his cases.

"The practice management seminars are also a must," advises Dr. Hancock.

"I've seen patients with leukemia, Hodgkin's disease, and a rare congenital heart defect I never saw even in Augusta."

Dr. Hancock found the Medical Fair to be a valuable experience and recommends it to present and future residents. "The communities are lined up," he says, a convenient arrangement for a resident seeking information about where to live and work. He recommends that residents talk with as many people as possible at the Fair and that they visit several communities afterwards.

The practice management seminars are also a must, advises Dr. Hancock. Making the transition from training to practice is "a real eye opener." The seminars give plenty of good pointers in the business side of medical practice, an area not always well covered in medical school.

Dr. Hancock seems to have made full and effective use of the Medical Fair, both for selecting a home and for entering practice. He and his family are happily settled in the town of their choice. As he said, they couldn't have done any better.

heart page
heart page
heart page

Magnesium Deficiency and Cardiac Arrhythmias

CORWIN M. MOKLER, Ph.D., *Athens**

Introduction

While magnesium (Mg) is the fourth most abundant metallic element in the human body, exceeded only by Na, K, and Ca, relatively little is known concerning the clinical effects of Mg deficiency. Indeed, the frequent occurrence of clinically significant Mg deficiency was not appreciated until the development of atomic absorption spectrometry and its use in clinical laboratories. Both demographic and clinical evidence exist to indicate that Mg deficiency may play a causative role in cardiac disease. Epidemiologic studies in Finland and Ontario, Canada, have correlated the incidence of sudden death with the hardness of drinking water, i.e., the concentration of calcium and magnesium salts. Administration of Mg salts to patients with arrhythmias of many types has corrected them or made them more manageable. Thus, this element is deserving of greater attention than it has previously been given.

Clinical Observations

A variety of conditions may lead to a depletion of body stores of Mg. Negative Mg balance can be the result of inadequate dietary intake over a prolonged period of time, as in chronic alcoholism. Various malabsorption syndromes such as steatorrhea, extensive bowel resection, chronic diarrhea, or excessive use of purgatives may result in subnormal Mg levels in blood and tissues. Surgical patients may become Mg deficient due to postoperative care or the metabolic responses to trauma. Other conditions including endocrine and renal disorders may cause total body Mg deficiency which may go undetected because it clearly can exist without hypomagnesemia. In congestive heart failure, Mg depletion is common and is exacerbated by the cardiac glycosides and some diuretic drugs. Metabolic studies during recovery from diabetic ketoacidosis have linked a body deficit of Mg with the acidosis and with glycosuria which greatly increases urinary Mg.

Body stores of Mg are concentrated in bone and in intracellular fluids. Normal serum concentrations range from 1.6-2.1 mEq/liter, and this small fraction of the estimated 2000 mEq of the whole body exchanges quite slowly with tissue stores. The erythrocyte or leukocyte content and 24-hour excretion of Mg are better indicators of the true state of body stores because of marked renal conservation in deficiency states. When Mg deficiency occurs, the most distinctive symptoms are neuromuscular. Chvostek sign is frequently present as are tremors, myoclonic

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jerks, and convulsions. Cardiovascular manifestations are less common and are probably related to the role of Mg in intracellular processes in the heart. Some membrane events are influenced by hypomagnesemia, but ECG changes are not striking. Serum Mg of less than 1.0 mEq/liter causes depressed ST segment and inverted T waves in precordial leads. Other electrical effects, if present, may be due to the intracellular depletion of $K+$ which is caused by the Mg deficit (see below).

Functions of Mg in the Heart

Mg is a key intracellular cation and participates in many physiologic and biochemical functions related to metabolism, transport of ions, and striated muscle contraction. The activity of membrane Na-K-ATPase in cardiac muscle is dependent on $Mg++$ as a cofactor, and a pronounced depletion of intracellular $K+$ results when Mg is deficient on either an acute or chronic basis. Mg is also bound in significant quantities by mitochondrial membranes where it takes part in many enzymatic reactions concerned with generation and use of high-energy phosphate compounds. Mg ATP is the substrate for myofibrillar ATPase during contraction of heart muscle. Finally, Mg is intimately involved in the uptake and release of calcium by myocardial sarcoplasmic reticulum, a process which is vital in myofibril contraction and relaxation.

Occurrence of Arrhythmia in Mg Deficiency

Several studies have linked Mg deficiency with an increased incidence of sudden death in ischemic heart disease. As was already mentioned, geographically defined areas having "soft" drinking water with low calcium and magnesium content have been shown to have a higher rate of sudden death due to lethal arrhythmias, but a causal connection is disputed. Analysis of normal myocardium obtained at necropsy from patients suffering sudden coronary death has shown significant reduction in $Mg++$ and $K+$ concentration. However, a firm relationship between Mg deficiency and lethal arrhythmias is elusive, in part because other metallic ions are also altered in coronary heart disease: the hypoxic or ischemic myocardium loses $Mg++$ and $K+$, and gains $Ca++$ and $Na+$. Also, while some studies found significant correlation between low serum Mg levels and the occurrence of serious arrhythmias in myocardial infarction (MI), others did not. Tissue concentrations of Mg are understandably not commonly assessed in such studies.

Cardiac rhythm disturbances do occur in hypomagnesemia without MI and are apparently caused by the ion deficiency. Iseri et al[3] documented two such cases of lidocaine resistant atrial and ventricular arrhythmias which responded well to parenteral $MgSO_4$. They also review four other clinical reports involving seven patients in whom arrhythmias and Mg deficiency appear to be causally related. According to other reports, a variety of atrial and ventricular arrhythmias have been successfully treated with intravenous (IV) $MgSO_4$, the best results being obtained with digitoxic arrhythmias. Results were transient when single bolus injections were given because of rapid uptake by tissues and excretion by the kidneys. Where IV infusions of Mg salts were used, better success was seen in converting non-digitalis arrhythmias.

Perhaps the widest experience with Mg in arrhythmias has been gained in treating digitalis toxicity. Twenty-one patients with digitalis toxicity arrhythmias had significantly lower serum Mg levels than eurhythmic controls in one study. Since Zwillinger first used Mg to treat arrhythmias of patients with digitalis toxicity in 1935, a number of clinicians have used Mg for that condition with varying degrees of success. The mode of action of Mg in correcting such rhythm defects is not clearly known, but several possibilities exist: (a) Digitalis is known to inhibit the membrane Na-K ATPase which normally is responsible for keeping intracellular $K+$ high and $Na+$ low. This enzyme requires Mg as a co-factor, and Mg supplementation may increase the ATPase activity, preventing significant $K+$ loss. Mg does depress $K+$ efflux from cells, at least in rat myocardium; (b) $Mg++$ does have effects on the transmembrane action potential, especially in the presence of

reduced Ca++ concentration in the extracellular fluid. The nature of the Mg effects, i.e., prolongation of effective refractory period more than that of the action potential duration, would be antiarrhythmic for reentry types of arrhythmias.

Summary

A firm relationship between Mg deficiency and cardiac arrhythmias is elusive. Refractory arrhythmias, particularly when caused by digitalis intoxication, have been successfully treated with oral and parenteral Mg supplements. Addition of Mg salts to IV fluids appears to have some prophylactic merit in postsurgical or traumatic patient care, but there is no support for the general use of Mg supplements to the diet. Clinically, Mg deficiency should be considered as a possible complicating factor when arrhythmias accompany other conditions.

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A.C.E.

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DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Nat recommended for children under 12 years af age. Tablets are ta be swallawed whale.

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CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma. bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypatensian/hypertension, faintness, dizziness, tinnitus, headache, incoordinatian, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours. not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: ½ the adult dose, not ta exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: ½ teaspoonful every 4 hours, not no exceed 3 teaspoonfuls in any 24-haur period. Children under 2 years of age: Use as directed by a physician.

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New Challenges — New Faces — New Dome

I HAVE SERVED with pleasure on the MAG Legislative Committee since 1962 and as its Chairman for the past 8 years. It has been a difficult task to fill the shoes of my predecessor, Harrison Rogers, who, as you know, is now Speaker of the AMA House of Delegates. My responsibility as your Chairman is for both the state legislature and the Georgia delegation in the U. S. Congress.

My comments to you at this time concern both but are primarily aimed at the state legislature which convenes Monday, January 10, 1983. Georgia has the second largest state legislature in the nation, with 56 state senators and 180 state representatives.

This session will see the largest number of newly elected representatives and senators that anyone can remember. These 64 freshmen, along with a new governor, Joe Frank Harris, present a difficult challenge to the MAG and others in that we do not know at this point where their interests are and how they view Georgia physicians and the medical system as we know it today. These new faces certainly pose new challenges to those concerned with legislation being considered under the newly constructed gold dome. In addition, we must continue to make contact with the remaining 172 legislators.

There will be new medical legislation introduced, at least 80 bills, which will be the responsibility of the Legislative Committee to analyze and take appropriate action on consistent with our directions from the Executive Committee. This makes it imperative that you assist us in creating the proper rapport with legislators and assist us in educating them as to the health consequences of these bills to the people of this state.

There are several ways you can be of valuable assistance:

1. Participate in the Physician Involvement Program (PIP)
2. Communicate with legislators in your communities
3. Participate in the Doctor-of-the-Day Program
4. Make phone calls and send personal letters and telegrams during the session.

Let me emphasize the Physician Involvement Program. This is the most successful legislative activity which MAG has originated. At least 10 physicians per day participate in this program each day the legislature is in session.

The physicians meet at the Stadium Hotel at approximately 8:30 a.m. in the MAG meeting room and are briefed by a member of the MAG staff on the issues of concern and the plan for that day. This year the staff person will escort you to the Capitol after the briefing and help you all day in contacting your state legislators, take you to committee meetings, and generally be available to answer all the questions you have during the day.

The members of the General Assembly have stated many times the value of the Physician Involvement Program (PIP) and the importance of seeing physicians

from their communities interested enough to come to the Capitol for at least one day during the session. I cannot stress enough the importance of your participation in this program. Your participation and that of your colleagues may have a profound effect on the future of your practice.

Call Carol Greene at MAG (1/800-282-0224 or in Atlanta, 876-7535) today to schedule the day of your choice for the Physician Involvement Program for 1983.

Your, and only your, involvement in the legislative efforts of MAG will produce the results on medical legislation that the physicians of Georgia desire.

I look forward to seeing you at the PIP briefings, and thank you in advance for your help in making the 1983 legislative program of MAG a success.

James A. Kaufmann, M.D.
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The Impact of the Tax Equity and Fiscal Responsibility Act of 1982 on the Retirement Plans and Professional Corporations of Physicians

WILLIAM A. GRAY, *Atlanta**

On September 3, 1982, President Reagan signed into law the Tax Equity and Fiscal Responsibility Act of 1982 (''TEFRA''). Two of the aims of TEFRA were to restrict the advantages of retirement plans of closely-held corporations and to achieve parity between the retirement plans of partnerships and professional corporations. These goals were reached at the expense of introducing highly complex provisions into an already confusing area of the tax law. The new TEFRA provisions represent the most comprehensive changes in the employee benefits area since the enactment of the Employee Retirement Income Security Act of 1974 (''ERISA'') and *will necessitate the amendment of every qualified retirement plan.*

Keogh Plan Liberalization

For physicians practicing as sole practitioners or partners, TEFRA will probably be welcomed because of its provisions designed to raise Keogh plans to a rough position of ''parity'' with corporate retirement plans, effective for years beginning after December 31, 1983. At that time the special 15% or $15,000 contribution limit for Keogh plans and the special benefit limitations on defined benefit Keogh plans will be eliminated. In addition, changes in former Keogh limitations such as the following will become effective:

—Keogh plans will not be required to have banks as trustees;
—Profit sharing Keogh plans will no longer be bound to a definite contribution formula;
—The requirement that Keogh plans covering ''owner-employees'' must provide 100% vesting for all participants will be eliminated; and
—Keogh plans will no longer be subject to integration rules different than those which apply to corporate retirement plans.

Although TEFRA has removed most of the differences between Keogh plans and corporate retirement plans, it is important to remember that the ''top-heavy'' rules (discussed below) will apply to most physicians' retirement plans in such a way as to impose on both Keogh plans and corporate retirement plans restrictions not formerly placed on corporate retirement plans.

* Prepared at the request of the Medical Association of Georgia. Mr. Gray is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

New Contribution and Benefit Limits

Prior to TEFRA there were limitations on benefits payable from a defined benefit pension plan and limitations on annual additions to a participant's account in a defined contribution plan (such as a profit sharing, money purchase pension, savings, thrift or target benefit plan). TEFRA lowers the maximum annual benefit payable under a defined benefit pension plan from $136,425 to $90,000 and lowers the maximum annual addition to a defined contribution plan participant's account from $45,475 to $30,000. The new limits will become effective in 1983, and will remain frozen for 1984 and 1985. Beginning in 1986, the limits will be adjusted for cost-of-living increases based upon the Social Security benefits index formula.

If an individual is a participant in both a defined benefit pension plan and a defined contribution plan maintained by the same employer, an overall limitation exists on the maximum benefits and contributions which can be derived from both of the plans. The fraction of the separate limits used by each plan is computed and totalled. The sum of the fractions under the old law was subject to an overall limit of 1.4, or 140%. For example, if the highest benefit allowed (100%) is provided under a defined benefit pension plan, only 40% of the highest annual addition allowed can be made under the company's defined contribution plan. The overall 1.4, or 140%, limit is attained by adding 100% to 40%. TEFRA redefines the method used in computing the limits in a manner which generally preserves the 1.4 limit for lower-paid participants, while imposing a lower 1.25 limit on higher-paid participants. For key employees in top-heavy plans, which are discussed in detail below, this limit is further reduced to 1.0 in many cases.

Prior to TEFRA, many defined benefit pension plans provided a normal retirement age of 55 in order to increase annual contributions to the plan. Under TEFRA, however, this planning device will no longer be as useful, because the maximum allowable benefit for many highly compensated participants will be actuarially reduced if payments commence before age 62.

Changes in the contribution and benefit limits for existing retirement plans will take effect for plan years beginning in 1983. However, for retirement plans not in existence on July 1, 1982, the new limits are already applicable. It should be noted that although TEFRA does not require actual amendment of retirement plans until 1984, compliance with the new limits is required starting in 1983. Arguably, compliance with TEFRA without first making corresponding plan amendments could result in disqualification of the retirement plan. Therefore, retirement plan sponsors with an executive whose benefit or annual addition approaches the new limits should make the necessary amendments in 1983.

Top-Heavy Plans

TEFRA imposes many new tax-qualification requirements on both corporate and noncorporate plans which primarily benefit an employer's key employees (referred to as "top-heavy" plans). Retirement plans are deemed to be top-heavy for any plan year in which, in the case of defined benefit pension plans, the benefits accrued by key employees represent more than 60% of the present value of all accrued benefits and, in the case of defined contribution plans, the sum of the account balances of key employees for the plan year exceeds 60% of the sum of the account balances of all participants. It would be rare to find a retirement plan with doctor participants which is not top-heavy.

When a retirement plan is top-heavy, restrictions on the amount of compensation which may be taken into account in determining contributions or benefits are imposed. For any plan year for which a plan is a top-heavy plan, no more than $200,000 of an employee's compensation may be taken into account in determining contributions or benefits.

More stringent schedules for vesting of benefits are required for top-heavy plans than for other retirement plans. Benefits under top-heavy plans must become either 100% vested (nonforfeitable) after three years of service with the employer or, alternatively, benefits must vest on a graded schedule with 20% vesting after two

years, 40% after three years and so forth, until 100% vesting is achieved after six years.

Top-heavy plans must provide minimum non-integrated (not offset by Social Security taxes) contributions and benefits to non-key employees. For plan years during which a defined contribution plan is a top-heavy plan, annual additions for non-key employees must be at least 3% of compensation, a lesser annual addition being permitted only if annual additions for all key employees are also below 3%. For plan years during which a defined benefit pension plan is a top-heavy plan, each non-key employee who is a plan participant must accrue a benefit which, when expressed as an annual retirement benefit, is at least 2% of annual compensation, multiplied by the number of years of service the employee has with the employer. However, an employee's minimum benefit need not be greater than 20% of average annual compensation.

This article has already discussed the 1.4 and 1.25 limitations on benefits and contributions in cases in which an individual participates in both a defined benefit and a defined contribution pension plan. For many physician employees in top-heavy plans, a lower 1.0 limit will be required for multiple plan contributions and benefits. Higher-paid key employees can utilize the higher 1.25 limit only if an extra minimum benefit or contribution is provided to non-key employees who participate in the retirement plans and if the accrued benefits of key employees do not exceed 90% of the accrued benefits of all participants.

TEFRA imposes an additional 10% income tax on any distribution from a top-heavy plan to a key employee which occurs before the employee attains age 59½, unless the distribution is made on account of death or disability. Additionally, distributions from a top-heavy plan to a key employee must commence no later than the year in which the employee attains age 70½, whether or not the employee separates from service with the employer.

TEFRA's top-heavy provisions apply to years beginning after December 31, 1983.

Defined Contribution Plan Integration

Many retirement plans maintained by physicians contain provisions through which the contributions by the employer or benefits payable under the plans are offset to a certain extent by Social Security payments. These plans are said to be "integrated" with Social Security. TEFRA imposes limitations on the extent to which defined contribution plans can be integrated by limiting the integration rate to the current old age, survivors and disability insurance (OASDI) tax rate applicable to employers. This will result in the maximum defined contribution plan integration rate being reduced from the current 7% level to a rate of 5.4% through 1984. Integrated defined contribution retirement plans must be amended to reflect the new rules no later than plan years beginning after December 31, 1983.

Loans to Plan Participants

Under prior law, a plan participant could be allowed to borrow against his account in a retirement plan without adverse tax consequences. Under TEFRA, a loan to a participant will be treated as a taxable distribution to the extent that the participant's outstanding loan balance under all retirement plans exceeds the lesser of (1) $50,000 or (2) one-half of the present value of his vested accrued benefit, but not less than $10,000.

TEFRA also requires that a loan under a tax-qualified plan provide for repayment within five years. However, an exception to the five year rule is made for loans which are applied toward acquiring, constructing, or substantially rehabilitating any dwelling which is used as the principal residence of the participant or a member of the participant's family. Such a loan will still be subject to the dollar restriction set forth in the preceding paragraph, but may be repaid over a period in excess of five years.

The new provisions regarding participant loans are already effective.

Withholding Provisions

Prior to TEFRA, income tax withholding on distributions from tax-qualified plans was not required unless the participant affirmatively requested it, which, of course, seldom happened. Effective January 1, 1983, TEFRA turns the tables and requires income tax withholding of retirement plan payments unless the participant affirmatively elects *not* to have withholding. The plan administrator will have the primary responsibility for notifying participants of the withholding provisions and ensuring that monies are withheld if the participant does not elect out. This responsibility must be taken seriously because failure to withhold can result in penalties and ultimate responsibility by the plan administrator for a participant's unpaid income taxes. Because of the impending effective date of these provisions, employers with retired participants or participants nearing retirement should begin to gear up now for the notification process.

Employee Leasing

Some physicians, particularly in California, have attempted to avoid providing retirement plans for their staffs by ''leasing'' all their non-physician workforce from an independent agency. Under TEFRA, if a ''leased'' employee performs services for a single medical practice on a full time basis for at least twelve months, he or she must be treated as an employee of the medical practice for retirement plan purposes. An exception is provided if the ''leased'' employee is covered under a qualified money purchase pension plan providing a fully vested annual contribution of 7½% of compensation.

Estate Tax Exclusion

Under prior law, there could be an unlimited estate tax exclusion for distributions from a retirement plan at death. TEFRA has changed the law to limit this estate tax exclusion to $100,000 for deaths occurring after 1982. Persons with substantial accrued benefits under retirement plans should consider revising their estate plans.

Group Term Life Insurance

Under present law, employees are not taxed on employer-paid premiums providing up to $50,000 of group term life insurance coverage. Effective for taxable years beginning after December 31, 1983, most physician employees will be required to include the cost of the insurance in their income unless certain non-discrimination standards are met.

Corporations Providing Personal Services

One of the most important provisions of TEFRA to certain physicians utilizing professional corporations is a section which allows the Internal Revenue Service to reallocate income and deductions between a ''personal service corporation'' and its employee-owners, if the allocation is necessary to prevent tax avoidance or clearly to reflect the income of the corporation and its owners. This rule will apply only if substantially all of the services of the personal service corporation are performed for one other corporation or partnership and the principal purpose for forming the corporation was to secure a tax benefit which would not otherwise be available. Therefore, this provision will generally not affect professional corporations which serve the general public. However, a professional corporation which provides services solely for a medical partnership (a so-called ''partnership of P.C.'s'') will fall within the ambit of the new rule. In addition, the broad scope of the new provision may reach some more traditional professional corporations, like those of hospital-based physicians such as pathologists and radiologists.

This reallocation power of the Internal Revenue Service is effective for taxable years beginning after December 31, 1982. In the belief that this provision and the Keogh liberalization rules of TEFRA will cause many professionals to desire to liquidate their corporations, the Congress has provided a special relief provision for personal service corporations liquidated in 1983 and 1984.

Conclusion

Although TEFRA will largely eliminate the discrimination in tax treatment against partnership and sole practitioner retirement plans, it will do so at the expense of imposing complex new limitations on the retirement plans of all professionals, whether incorporated or unincorporated. In addition, TEFRA has given the Internal Revenue Service a powerful tool in tax contests involving professional corporations which provide all of their services for a single partnership or corporation.

Although it is too early to make accurate projections, it appears that most extant professional corporations which deal with the general public will continue in their present form. Even after TEFRA, there are still benefits to practicing in corporate form, such as limited liability, the opportunity to deduct health and disability insurance premiums, group term life insurance availability, and the ability to accumulate income at low tax rates and to defer income through the choice of a corporate year-end. The cost and bother of liquidating will likely appear unwarranted to the shareholders of such corporations. However, it is to be expected that future incorporations will diminish.

On the other hand, professional corporations which render substantially all of their services to a single entity will be significantly effected by TEFRA due to the reallocation power extended to the Internal Revenue Service. Although the new provision represents a significant threat to the tax benefits of incorporation, some such incorporated professionals will be willing to risk the threat in order to retain the benefits still available to corporations and in order to avoid the costs of liquidation. It appears, however, that the future establishment of partnerships of professional corporations will be substantially deterred.



president's letter



The Gold Rush Is On

A 12.7 MILLION DOLLAR AWARD in Florida, a 4.2 million dollar award in Georgia, and similar incredible sums of money given to "medically injured" people around the country attest to one fact: plaintiff attorneys, through their influence on patients and on rather ill informed and irresponsible juries, have struck gold. It has been implied, and even stated, that physicians through their professional liability insurance companies have limitless resources stashed away in their vaults, awaiting the taking by shrewd attorneys and deserving patients. It simply is not so. Unjustified awards of this magnitude will quickly disrupt the entire medical care system — including physicians, clinics, and hospitals.

In August, the MAG sponsored a legislative seminar, in which some of Georgia's most distinguished legislators were asked to teach us about the legislative process. The seminar, however, had the dual purpose of allowing us to become acquainted with our representatives on an informal basis and to discuss with them some of the issues which we face demanding remedial action by the legislature. Perhaps foremost among matters demanding action this year is the professional liability crisis — and it is a crisis! What can be done?

The alarming escalation of frequency and severity of malpractice claims is not just a problem facing hospitals and physicians. The staggering sums of money awarded must ultimately come from patients, thus becoming a significant factor in the increase in all medical costs. But the awarded monies are only the tip of the iceberg. Otherwise unnecessary tests, x-rays, and hospitalizations ordered as a protection against medical malpractice claims increase utilization and constitute as much as an estimated 30% of the total health care expenditures. This is 30% of the three hundred billion dollars spent on health care services annually in this country. From a personal perspective, I believe that these estimates are realistic.

Thus, in the professional liability fiasco, we are dealing with a social problem, not just with a medical economic problem. It is of such magnitude that we are compelled to take legislative action to offer relief to the public. We must look to our friends in the legislature to find meaningful and constitutionally sound tort reform laws.

It won't be easy. The plaintiff bar has to consider the hundreds of millions of dollars in contingency fees and will thus oppose any effort to improve the professional liability insurance climate. But, I believe it is possible — if we teach the business community and our patients what is involved. A well planned and coordinated effort will be necessary. Indiana has implemented model tort reform legislation which has withstood challenges in the courts. As a consequence, Indiana physicians and patients have been spared the apprehension, frustration, and expenses faced by physicians, hospitals, and their patients in most states.

The public welfare is involved. As concerned physicians, we cannot afford to allow the gold rush by the plaintiff bar to block efforts now to effectuate meaningful tort reform.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.

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Burgess, Russell E., Richmond—ACT (N-2)—ON
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Butt, Javed A., Whitfield-Murray—ACT (N-2)—IM
1217 Memorial Dr., Dalton 30720

Caselnova, Michael L., Muscogee—I&R
1096 Whisperwood Dr., Columbus 31907

Chernecky, Richard E., Gwinnett-Forsyth—ACT (N-2)—IM
719 Scenic Highway, Ste. D, Lawrenceville 30245

Church, John C., Whitfield-Murray—ACT (N-1)—DR
North Georgia Radiology, PA, P.O. Box 2339, Dalton 30720

Clarke, Douglas V., Muscogee—ACT—DR
P.O. Box 2787, Columbus 31994-3899

Davis, Christopher K., Peachbelt—ACT (N-2)—GS
P.O. Box 1179, Fort Valley 31030

Dawson, Virgil L., Muscogee—I&R
The Medical Center, P.O. Box 951, Columbus 31994

Dillon, Robert G., DeKalb, ACT—IM
2054-B Lawrenceville Highway, Decatur 30033

Duncan, Glenn A., Muscogee—I&R—FP
The Medical Center, Columbus 31994

Ferrari, Durval A., Cobb—ACT—DR
3949 S. Cobb Dr., Smyrna 30080

Holbrook, Robert H., Muscogee—I&R
The Medical Center, Dept. of Family Practice, Columbus 31994

Johnston, Michael W., Muscogee—ACT—EM
St. Francis Hospital, Emergency Dept., 2112 Manchester Rd., Columbus 31901

Kenerly, John L., III, Muscogee—I&R
The Medical Center, Columbus 31994

Kumar, Kakesh, Oconee—ACT—GS
307 S. Jefferson St., Eatonton 31024

Ladley, D. Mark, Muscogee—I&R
6006 Old Dominion Rd., Columbus 31904

Langston, Bernard, DeKalb—ACT—GP
4484 N. Shallowford Rd., NE, Atlanta 30338

Limehouse, Walter E., Jr., Clayton-Fayette—ACT (N-1)—PTH
Atlanta Emergency Group, 33 Upper Riverdale Rd., S-22, Riverdale 30274

Lopey, Nathaniel A., DeKalb—ACT—IM
3290 Memorial Dr., Ste. A-2, Decatur 30032

McLarnon, Michael C., Muscogee—I&R—FP
The Medical Center, Columbus 31994

Patel, Bharat J., Sumter—ACT—U
629 E. Forsyth St., Americus 31709

Patel, Ninna B., Sumter—ACT—OTO
629 E. Forsyth St., Americus 31709

Pound, L. Jelaine, Muscogee—I&R
The Medical Center, P.O. Box 951, Columbus 31994-2299

Pyburn, Robin, Hall—ACT (N-2)—IM
200 Prior St., Gainesville 30505

Ray, Michael K., Cobb—ACT (N-2)—EM
Kennestone Hospital, Emergency Room, Marietta 30060

Rigdon, Steven W., Tift—ACT (N-1)—IM
712 E. 18th St., Tifton 31794

Salanga, Rogelio B., South Georgia—ACT—GS
P.O. Box 908, Nashville 31639

Shannon, George W., Muscogee—ACT—FP/IM
The Medical Center, P.O. Box 951, Columbus 31994-2299

Stafford, Charles T., Decatur-Seminole—ACT—OBG
1323 E. Shotwell St., Bainbridge 31717

Watson, William W., Cobb—ACT (N-2)—EM
677 Church St., Marietta 30060

PERSONALS

First District

Grady Hugh Johnson, M.D., of Dublin, has been named Associate Fellow of the American Association of Clinical Immunology and Allergy.

The Mercer University Alumni recently paid tribute to **Darnell L. Brawner, M.D.,** at a dinner given in his honor. Dr. Brawner, an obstetrician and gynecologist, was lauded for his civic, professional, church, and alumni activities.

A. John Mooney, Jr., M.D., Director of Willingway Hospital in Statesboro, was presented with a plaque by the Bulloch County City Council in commemoration of his years of service in the Bulloch County area and for his outstanding contributions to the organization and development of the Bulloch County Alcohol and Drug Abuse Council.

Second District

Walter Carl Gordon, Jr., M.D., of Albany, was admitted as a Fellow to the International College of Surgeons during ceremonies on September 16, in Atlantic City, N.J. Dr. Gordon practices general and peripheral vascular surgery.

Third District

Columbus pediatrician, **A. J. Kravtin, M.D.,** was named Volunteer of the Year by the American Heart Association, Georgia Affiliate, at a recent awards ceremony. Dr. Kravtin is chairman of the Muscogee County Heart Health Education for the Young Committee and was honored for his work with the committee.



LaMar McGinnis, M.D., discusses his election as Chairman of the Executive Committee of the Georgia Division of the American Cancer Society with outgoing chairman, John P. Wilson, M.D., and Chairman of the Board, Charles R. Underwood, M.D.

Fourth District

In May, **LaMar S. McGinnis, M.D.,** was installed as President of the Alumni Association of the Medical College of Georgia. Also, in September, he became President of the Georgia Surgical Society, succeeding **J. Richard Amerson, M.D.** He was also recently elected Chairman of the Executive Committee of the Georgia Division of the American Cancer Society.

Fifth District

J. W. Veatch, M.D., of Atlanta, has been elected President-Elect of the Georgia Surgical Society.

William E. Silver, M.D., was recently elected to the Board of Governors for the American Academy of Otolaryngology — Head and Neck Surgery, representing the Greater Atlanta Otolaryngology — Head and Neck Surgery Society.

James A. Kaufmann, M.D., has been elected to the Board of Trustees of the Georgia State University Foundation.

A 2-day postgraduate course covering five areas of internal medicine will be held December 9-10 in Atlanta. The MKSAP VI Review Course is part of a nationwide series, sponsored by the American College of Physicians (ACP). **Charles M. Huguley, Jr., M.D.,** of Emory University School of Medicine is the course director.

Gilbert J. Kloster, M.D., was elected to a 3-year term on the Board of Directors of the Plastic Surgery Educational Foundation and Assistant Secretary to the American Society of Plastic and Reconstructive Surgeons at the national meeting held in Hawaii in October.

James S. Maughon, M.D., Director of Graduate and Continuing Medical Education at Georgia Baptist Medical Center, has been appointed by Dr. Vernon Crawford, Chancellor of the University System of Georgia, to the Search Committee to select a new President for the Medical College of Georgia.

Sixth District

LaGrange physician, **William B. Fackler, Jr., M.D.,** received the Heart of the Year Award for significant sustained impact on Heart Association work. The award was presented by the American Heart Association, Georgia Affiliate.

John A. Wells, M.D., of Macon, was named a Fellow of the International College of Surgeons. Dr. Wells specializes in general, abdominal, and peripheral vascular surgery.

John A. Wells, M.D., of Macon, and **I. J. Reddy, M.D.,** of Fairburn, were named Fellows of the International College of Surgeons at the annual meeting of the United States Section of the International College of Surgeons held in September in Atlantic City, NJ.

Rayasam Prasad, M.D., an allergist, has opened new offices in Lithia Springs.

Seventh District

Charles R. Underwood, M.D., of Marietta, was elected for a second 1-year term as Chairman of the Board of Directors of the Georgia Division of the American

Cancer Society at the Annual Assembly in Atlanta in September.

Tenth District

Shiraz H. Kassam, M.D., obstetrician and gynecologist, has joined the staff of the Rockdale County Hospital. Dr. Kassam was previously on the faculty of Obstetrics and Gynecology at the Medical College of Georgia, where he still maintains an active clinical faculty status.

SOCIETIES

The Medical Association of Atlanta and the MAG are sponsoring a medical seminar series, South African Adventure, by INTRAV. This seminar carries category 1 credit. For further information, contact Eleanor Somerville at MAA, Ph: 404-874-2714.

Officers of **the Georgia Medical Society** presented the nine-volume Ciba Collection to Armstrong State College during ceremonies on Wednesday, September 22. The collection published by the Medical Education Division of the Ciba Pharmaceutical Company, will be a reference source for Armstrong health education students. On hand for the presentation were GMS officers, Eloise B. Sherman, M.D., president, and Roland S. Summers, M.D., treasurer; Dr. Robert Burnett, acting president of ASC, and Dr. James Repella, dean of the School of Human Services.

The Douglas County Medical Society recently named the following physicians as its new officers: Joseph G. Bussey, Jr., M.D., president, J. Gordon Barrow, M.D., vice president, and James D. Hull, III, M.D., secretary-treasurer.

The Muscogee County Medical Society and the Auxiliary to the Muscogee County Medical Society held their annual joint meeting Tuesday, October 26, at the Harmony Club.

The Auxiliary was presented a check for $500 to be used for their Health Learning Project in the local schools.

The Society President, Marvyn D. Cohen, M.D., also presented plaques to the following Society members for work within the Society, the State, and local service projects: Mrs. Ann McWhirter, president of the Auxiliary to the Muscogee County Medical Society; Al Alvarez, M.D., chairman of the tennis tournament; Philip Brewer, M.D., for service to the Columbus museum; John Deaton, M.D., for serving as Society photographer; Gus Dudley, M.D., for service to United Givers; Jerry Everidge, M.D., chairman, Program Committee; George Hubbard, M.D., for his work with the TV show; Bill Jernigan, M.D., President-Elect and Chairman, New Member Committee, Chairman, Central Credentialling Committee; A. J. Kravtin, M.D., for service to local Heart Association; Bob Maughon, M.D., for service to Board of Health; Mac Molnar, M.D., for serving as Alternate Director to the MAG Board of Directors from this county; Bruce Newsom, M.D., for service at the state level, working with MAG Mutual, Chairman of Delegates, and active locally; Robert M. Patton, M.D., secretary of the Society for the past 3 years; Jack A. Raines, M.D., for service as Chairman of the Board of MAG and working at the local level; Richard S. Robbins, M.D., Public Relations Chairman; Dave Roberts, M.D., for service to the local chapter of the American Cancer Society; James H. Sullivan, M.D., for service as treasurer of MAG, local Board of Health, and working locally; Dave Varner, M.D., for serving as Editor of the *Bulletin* for the past year; Thomas A. Wade, M.D., for service to Columbus hospice; John D. Watson, M.D., Immediate Past President-Chairman Medical/Business Coalition, and Medical/Legal Committee; Philip Schley, M.D., for past service to the local school board.

DEATHS

Stewart Dixon Brown, Jr.

Stewart Dixon Brown, Jr., M.D., died October 5 at the age of 61. Dr. Brown attended Emory University, the University of Georgia, and was a graduate of the Medical College of Georgia. He was a member of the MAG, the Southern Medical Association, the Southeastern Surgical Congress, the Association of Surgeons of the Southern Railway, and the American Medical Association. Dr. Brown served as administrator of Cobb Memorial Hospital and was former chief of staff at Cobb Memorial.

Dr. Brown is survived by his wife, three sons, three daughters, one sister, and two grandchildren.

William P. Nicolson, III

William P. Nicolson, III, M.D., an Atlanta urologist, died October 6 in Edinburgh, Scotland, while attending the American Urological Society meeting there. Dr. Nicolson practiced in Atlanta for more than 30 years and was on the staff at Piedmont Hospital. He graduated from Washington and Lee University and the Medical College of Georgia. Dr. Nicolson was a member of the Atlanta Urological Society, the Georgia Urological Society, the American Urological Society, and the American College of Surgeons. Survivors include his wife, a daughter, and a son.

Harry Jacob Portman

Harry Jacob Portman, M.D., of Savannah, 73, died October 20. He graduated from the Medical College of Georgia and had served as city physician.

Dr. Portman is survived by his wife, three daughters, two brothers, a sister, and two grandchildren.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from July through September, 1982.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Patrick L. Anders, East Point
Catherine S. Andrews, Kennesaw*
Manuel P. Anton, Atlanta
Jack Hibler Blalock, Columbus
Sidney Allen Bell, Rome
Bernard A. Bergman, Smyrna*
Robert Martin Boger, Atlanta
Stephen Boyle, Conyers
Howard Leon Bruckner, Augusta
Horatio V. Cabasares, Perry
Louis Harold Cargill, Albany
John Scott Carman, Smyrna
Robert Glenn Carter, Brunswick*
Robert Mitchell Cates, Rome
Eric George Catz, Martinez*
Roy Gerald Chambers, Augusta
Yu-Chia Chao, Royston*
Floyd Childs Cooper, Griffin
William Dukes Crawley, Rossville
James H. Crowdis, Blakely
José A. Delgado, Milledgeville
Jimmy Lenon Dixon, Brunswick
William Hugh Earley, Atlanta
Julius Ehik, Smyrna
Dean C. Elliott, Martinez
Martin Frederick Evaldi, Augusta*
David Benton Fillingim, Savannah
Thomas Edward Flowers, Rome
Thomas V. Foster, Columbus
Ronald Allen Freeman, Macon
Edwin Steven Gerson, Riverdale
Aparna Ghosh, Augusta*
Patrick Edsel T. Godbey, Augusta*
Robert T. Goetzinger, Forest Park
Stephen Richard Goldman, Atlanta
Ralph R. Greene, Fort Oglethorpe
Alfred Joseph Grindon, Atlanta
Margaret F. Guill, Augusta
Kenneth C. Henderson, Macon
William Slocum Howland, Atlanta
James Dixon Hull, Douglasville
Ira Jay Isaacson, Atlanta
Jane B. Jennings, Savannah
Grady Hugh Johnson, Dublin
Kenneth Douglas Jones, Autusta
Willis Pope Jordan, Rome
Donna J. Kennedy, Fitzgerald*
Samuel R. Lathan, Atlanta
Robert C. Little, Augusta
Eugene M. Long, Augusta
George H. Longley, Augusta*
Donald E. Manning, Atlanta*
James Lee Mason, Atlanta
Stephen L. Matarese, Hinesville*
Seaborn S. McGarity, Augusta
Stanley Davis Meers, Atlanta*
Christine P. Milewicz, Decatur*
Robert Dempsey Milledge, Atlanta
William C. Miller, Macon*
Kenneth Curt Molkner, Atlanta
Benjamin F. Moss, Augusta
Bruce C. Newsom, Columbus
W. Lanier Nicholson, Hiawassee
John Henry Nolen, Marietta
Richard C. Parsons, Decatur
Zane Franklin Pollard, Atlanta
John Livingston Powell, Atlanta
Morgan Burgess Raiford, Atlanta
Derrell Wayne Ray, Atlanta
Marlan LeVan Rhame, Decatur
Billy B. Sellers, Augusta*
Charles F. Shaefer, Jr., Augusta*
Andrew Thomas Sheils, Savannah
Wayne Chris Sheils, Columbus
J. Dorsey Smith, Metter
Luther J. Smith, Columbus
Jeannette E. South, Martinez*
Franklin J. Star, Columbus
William Alexander Steed, Augusta
James L. Story, Thomasville
Yung-Fong Sung, Atlanta
Elmo R. Tamayo, Chatsworth
Corbett H. Thigpen, Augusta
J. Clarence Trice, Athens
Carlos Gabriel Tun, Atlanta
Joseph M. Van De Water, Macon
Thomas A. Wade, Columbus
David C. Waggoner, Atlanta
Jen Fang Wang, Dublin*
Lawrence L. Washburn, Atlanta
Paul T. Werner, Macon
Mary E. Miller Wiles, Blairsville*
Richard Elgin Wood, Columbus*

* Records show physician not a member of MAG at the time of this printing.

Committee Activities . . .

Education Committee

For several years, the MAG Education Committee has sent its Chairman, Accreditation Subcommittee Chairman, and staff member to Chicago for important meetings on continuing medical education. This year Dr. Victor Moore of Augusta, Dr. James Maughon of Atlanta, and Steve Davis represented the Medical Association of Georgia at two conferences. Here is their report.

Accreditation Council for Continuing Medical Education Conference on Accreditation, Thursday, September 30, 1982 — for 10 years the MAG has accredited Georgia hospitals and specialty societies as providers of top quality continuing medical education. Last year a relatively new national organization, the Accreditation Council for Continuing Medical Education (ACCME) developed guidelines, or "Essentials" for accreditation, which the MAG opposed for their inflexibility and unsuitability to CME providers in our state. In Chicago we learned that despite our opposition, the new ACCME Essentials would be put into operation sometime in 1983.

At the meeting we also learned that ACCME now seeks to bring all state medical associations into some uniformity as to the procedures they use in accreditating intrastate providers in CME. Last year at the state ACCME meeting, most states made it clear that ACCME must not challenge the right of the states as intrastate accreditors. Despite assurances that our right would not be questioned, we found that ACCME had drafted standards by which states would be recognized by ACCME as accreditors. Included in the draft were provisions for "probationary recognition" and even "non-recognition" of state medical associations if their accreditation procedures were found by ACCME to be deficient. Despite the vigorous opposition of the MAG, in which we received some encouragement from other state associations, the attendees approved the ACCME draft with minor revisions.

Tenth Annual AMA Conference on Continuing Medical Education for State Medical Associations and Specialty Societies, Friday-Saturday, October 1-2 — Here we learned that the AMA CME Advisory Committee had drafted interpretive language which when incorporated into the ACCME Essentials, would help to make them more flexible and practical. With some modification, this draft was approved by attendees.

From various discussion groups, we received strong encouragement for the Medical Association of Georgia to hold a seminar on the "do's-and-don't's" of conducting an accreditation site survey. We also learned how other states had annual conferences on CME for hospital directors of medical education, medical schools deans, and all practitioners involved in CME. We think this is a good slant for our next "Biennial Conference on CME," next slated for 1983.

Public Health

In order to increase MAG's input into state public health policies and programs, the Executive Committee invited two key state health officials to meet with the Committee on October 17. James G. Ledbetter, Ph.D., Commissioner of the Department of Human Resources, and James Alley, M.D., Director of DHR's Public Health Division, briefed the Committee on the current activities of DHR in the area of public health.

Dr. Ledbetter recounted some of the budgetary problems brought on by both Federal and State efforts to reduce spending. Following the current trend toward less government, the DHR is attempting to shift more decisions regarding services to the local level. In this process the state has established the following priorities in the maintenance of its involvement: 1) serving individuals who are severely disabled; 2) prevention programs to prevent people from becoming severely disabled; and 3) resource development. DHR plans to hold community forums to allow local people to be involved in the decision process.

Dr. Alley expressed his desire for the public and private sectors of medical care to work together to alleviate suffering, improve quality of life, change disease patterns and in sharing resources to meet these needs. Specifically, he outlined three major goals of his Division: 1) reduction of infant mortality in Georgia from 14.6 to 9.2 per 1000 live births; 2) development of a project called "Operation Lifestyle" to educate people about Georgia's major disease patterns — heart disease, stroke, cancer, accidents, and drug abuse; and 3) collaborative interdependence of the public and private sectors. For one project, he suggested that the MAG cooperate with DHR in the development of a handbook on public health services.

After extensive discussion, the Executive Committee and the DHR representatives agreed that intensified liaison between the two organizations is needed. It was decided that MAG and DHR will work together in several areas, including: the preparation of the handbook of public health services; the community forums; distribution of information regarding public health programs; development of policies relating to public health, both within MAG and DHR; and public education, specifically the program "Operation Lifestyle."

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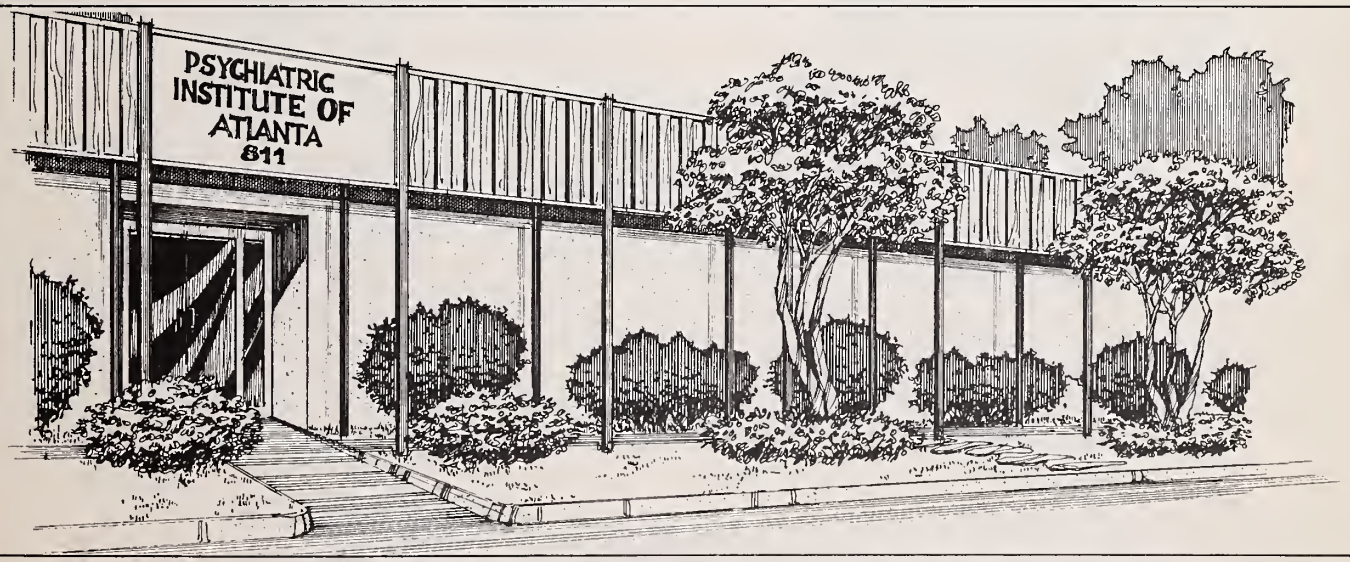
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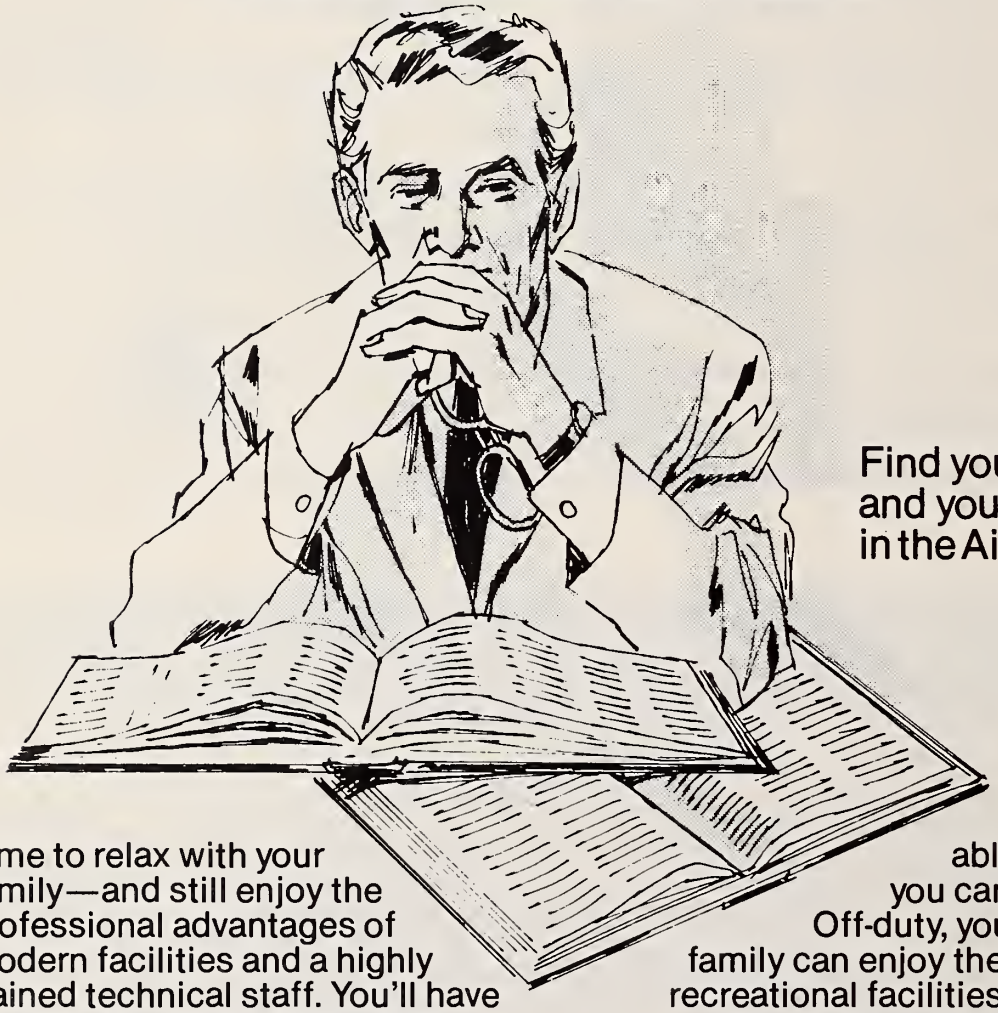


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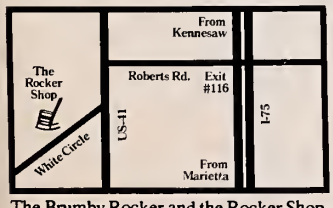
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